THE EXPERIENCES OF INTRAPARTUM NURSES IN A NORTHEASTERN ONTARIO, CANADA SETTING IN PROVIDING LABOUR SUPPORT

by

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Abstract

A qualitative, interpretive descriptive study, using a symbolic interactionism theoretical framework, was conducted to explore the experiences of intrapartum nurses in a Northeastern Ontario, Canadian hospital and the meaning they place on providing labour support. There is substantial literature that supports the many benefits of labour support provided by intrapartum nurses. Throughout the intrapartum experience, the nurse influences, creates, and shapes the meaning and understanding of the labour experience. Semi-structured interviews were conducted with eight registered nurse participants recruited from a hospital. Interviews were transcribed and analyzed for themes. The following five themes emerged from the data: Enhancing the birthing experience of women through labour support, birthing technology and medical paradigm, birthing environment that influences the intrapartum nursing care, interprofessional collaborative relationships and intrapartum specialists. The findings suggest that intrapartum nurses have been drawn away from providing labour support and have become preoccupied with managing technology and competing priorities for their time and attention. Barriers and challenges in the experience of nurses providing labour support were identified. Suggestions for nursing practice include the importance of continuing education for labour support techniques and tools. Training is important for all nurses who practice in hospitals where less labour support may be offered due to high intervention rates. Competence validation would include creating a certification for labour support that is both theoretical and a simulated experience.

Keywords: labour support, intrapartum nurse, perinatal nurse, childbirth, birth, caring during labour, labour and delivery, intrapartum care

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Chapter One: Introduction

This interpretive description study was an exploration of the experiences of intrapartum nurses in a Northeastern Ontario, Canadian setting and the meaning they place on providing labour support.

Background

A typical scenario on the birthing unit reflects a labouring woman arriving with contractions who is then directed to triage for assessment by an intrapartum nurse. Once in triage the patient is requested to change into a convenient and accessible green hospital gown that is symbolic of a patient and sickness. She is asked to provide a urine specimen and then routine blood work is collected. She is confined to a narrow stretcher while placed on an electronic fetal monitor with yellow straps holding the transducer and tocometer in place to ensure the baby is okay. She is positioned in a suitable way to ensure that a tracing of the fetal heart rate is obtained. She may have an intravenous started or may be told to refrain from eating or drinking "just in case." This begins her experience before she is transferred to a birthing room. Once in the birthing room, the electronic fetal monitoring continues and the labouring woman is once again restricted to bed to allow for a tracing of the fetal heart rate and contraction pattern. To follow the medical timeline, she may be started on oxytocin to expedite the labour process. As a result, her contractions increase in intensity, frequency and duration causing anxiety and inability to cope with the pain and thus resulting in her pleading for an epidural, which further restricts her to the confinement of her bed and prohibits her from moving and changing positions.

Birth should be a woman-centered event that is gentle and peaceful and happens at it's own rate (Dwinell, 1992). A woman in labour should be respected along with her questions and

ideas. She should be given autonomy to give birth when, where and how she chooses. When a women-centered philosophy is used, traditional medical interventions and technology then become options for women (Dwinell, 1992). The woman is assisted by the nurse to tap into her strength and power to give birth. When a woman in labour says she can't do it, she needs a nurse who knows that she can and has the ability to empower her with the knowledge, patience and strength to show her how. Woman-centered philosophy acknowledges that women require assistance and support by others, however, recognizes that women possess an inner knowledge and strength that gives them the wisdom and power to know how to give birth (Dwinell, 1992). "Birth is not only about making babies. Birth is also about making mothers – strong, competent, capable mothers who trust themselves and know their inner strength." (Rothman, 1996, p.254)

The intrapartum nurse is capable and competent of offering much more to the labouring woman than managing the birthing machines under a traditional male logic (Giarratano, 2003). Labour support symbolizes different meanings to each nurse who provides it and how they provide labour support. The role of the nurse while providing labour support should be a woman-centered approach that recognizes that the social, psychological, physical and spiritual needs affect birth and should be considered at all times. This study explored the meaning of, and experience of the nurse with providing labour support.

Nurses Role

The birth experience for most women changed during the early 1900's from an event that occurred at home supported by midwives, family members and friends to a hospital birth that occurred in a sterile environment managed by physicians (Leavitt, 1986; Mason, 1988). The focus of this medical model then shifted the focus of birth from a natural process when women listened to their bodies to one that included an efficient removal of a fetus by physicians that

included diagnoses, treatments and interventions (Katz Rothman, 1996; Sherrod, 2017). As the request for anesthesia became more prevalent in hospital births, the need to administer and monitor pain relief during labour began to shape the role of the nurse as they became increasingly immersed in medical and technical duties and responsibilities (Gibson, 2017; Sherrod, 2017). These duties began to overshadow the caring and supportive role that nurses traditionally offered for a woman in labor (Gibson, 2017; Sherrod, 2017). Fairman and D'Antonio (2008) suggested that nursing from a historical perspective values both constructing things and making things work. "It relishes technological challenges, and it sees the patient beneath the machines" (p.438). The hallmark of intrapartum nursing is the formation of a caring and supportive relationship between a labouring woman and the nurse. Childbirth is a time when women place their trust in nurses as they turn over control of their bodies (Fairman & D'Antonio, 2008).

Canadian Nurses Association (CNA) and The Association of Women's Health, Obstetric and Neonatal Nurses AWHONN (2009) have published a collaborative document entitled *Standards for Perinatal Nursing Practice and Certification in Canada* that describes the role of the registered nurse in Canada practicing in perinatal nursing. The document is intended to guide perinatal nursing care for childbearing women and their newborns. The document outlines standards of practice for perinatal nurses and standards of professional performance along with measurement criteria that describe the diverse roles and behaviours for which the nurse is accountable. The Association of Women's Health, Obstetric and Neonatal Nurses (2009) provides a definition of the specialty practice of perinatal nursing in Canada:

> Perinatal nursing addresses the care of women, newborns, and their families throughout the childbearing experience and in a variety of settings. These settings include

> communities and hospitals and range from small rural centers where perinatal nursing is one component of nurses' overall responsibility to larger centers where perinatal nurses may focus exclusively on antepartum, labour and birth, postpartum, or newborn care. Perinatal nurses care for healthy women and newborns as well as those with complex care requirements. (p. 3)

The importance of a woman's childbirth experience when receiving labour support from an intrapartum nurse has been documented in the literature (Corbett & Callister, 2000; Miltner, 2002; MacKinnon, McIntyre & Quance, 2005; Sauls, 2006; Edmonds, O'Hara, Clarke & Shah, 2017; Sherrod, 2017). It is intrapartum nurses who are often the primary caregivers for women giving birth at the hospital admitted under a physician or obstetrician (Edmonds et al., 2017; Sherrod, 2017). Intrapartum nurses may also play a role when a woman is admitted under the care of a midwife. There is strong evidence that supports the important roles of intrapartum nurses. Women during childbirth have reported increased satisfaction when nurses spend time with them; provide comfort, reassurance, demonstrate empathy, and provide teaching (Corbett & Callister, 2002; MacKinnon et al., 2003). Women who perceived caring actions from their intrapartum nurse, felt empowered and conversely women who perceived non-caring behaviours felt discouraged (James et al., 2003). It is the quality of labour support perceived from the labouring woman which contributes to whether the she reflects on her childbirth experience as depersonalizing and degrading or one that increased her self-esteem and self-confidence (Hodnett, 1996).

Nurses providing intrapartum care have a multidimensional role in labour and delivery including interventions such as maternal and fetal assessment, proficiency in technical skills, interpersonal skills and interprofessional collaboration (Birkhead, Callister, Fletcher, Holt &

Curtis, 2012). While many of the interventions are based on the physician's orders, there are many care practices that nurses implement autonomously and are responsible to manage (Simpson, 2005). Intrapartum nurses must deal with the complexity of a fluctuating census of women in labour together with varying levels of acuity. Upon admission, intrapartum nurses will assess and identify any maternal-fetal risks and provide care accordingly. Intrapartum nurses are responsible for managing and monitoring the woman and fetus during labour. Although the choice to initiate oxytocin for induction or augmentation of labour is made by the physician, it is the nurse who will make the decision to titrate the oxytocin based on their maternal and fetal assessment (Simpson, 2005). Nurses may be responsible for classifying second stage labour and managing and supporting pushing efforts accordingly and notifying the physician when delivery is imminent (Simpson, 2005). Nurses have to learn to balance their varying roles and ensure that women receive optimal support in labour. Intrapartum nurses providing care for women in labour must possess the capabilities to recognize, communicate and intervene in commonly occurring urgent and emergent situations and to provide emergency care in the absence of the obstetrician, physician or midwife (AWHONN, 2009).

A nurse-managed unit is where obstetricians are not routinely in-house or available on the unit, and communication generally occurs via telephone. In a nurse-managed unit, the nurse plays an essential, autonomous role using medical orders and established protocols and policies to assess and manage women in labour (Edmonds & Jones, 2013). The obstetrician comes to the birthing unit when the nurse determines that birth is imminent or if there are concerns as identified by the nurse (Simpson, 2000; James et al., 2003; Edmonds & Jones, 2013). A nurse-managed unit is in contrast to a teaching model in which a resident, fellow or attending physician is available and present on the floor taking responsibility for decision-making (Edmonds &

Jones, 2013). In the teaching model, it is the residents and obstetricians that make the decisions about management of labour (Simpson, 2005).

Technology

Labour is a normal physiological process and promotion of childbirth should involve a balance between non-intervention and the judicious use of technologies that support safer outcomes for mother and baby. However, the twenty-first century Canadian birth experience is characterized by advances in medical technology accompanied by an increase in intervention-intensive labour and delivery. Hospital environments have embraced a high technology model of labour and delivery care (Zwelling, 2010). Although 60 percent of women enter labour without pre-existing or obstetrically associated health concerns (PHAC, 2009), giving birth in Canada has become technical and medicalized (Hoerst & Fairman, 2000; Callister et al., 2009; Adams & Saul, 2014). In a Canadian study, Koteles, deVrijer, Penava & Xie (2012), reported that obstetricians and specifically, newly graduated ones, have a preference towards the use of birth technology. The rate of cesarean sections in Canada has seen an increase in the past 50 years (Farine & Shepherd, 2012). The cesarean section rate was five percent from the 1940s to 1970s and then rose to 15 percent and remained unchanged until the late 1980's where a dramatic increase would see a rise in caesarean births to 21 percent and then again to 26.9 percent in 2010 (Farine & Shepherd, 2012). Canadian Institute for Health Information (CIHI) (2018) in the discharge abstract database reports childbirth indicators by place of residence for 2016-2017. Total caesarean section rates include both primary and repeat caesarean sections across Canada are averaged at 28.2 percent. In comparison, the rate of caesarean sections in Ontario was 28.4 percent and Northeastern Ontario, 30.5 percent. A Canadian average of vacuum-assisted vaginal deliveries of 9.1 percent and forceps-assisted vaginal deliveries was 3.4 percent. In comparison,

Ontario reports 9.1 percent vacuum-assisted vaginal deliveries and 2.8 percent forceps-assisted vaginal deliveries. Northeastern Ontario reports 7.3 percent vacuum-assisted vaginal deliveries and 1.9 percent forceps-assisted vaginal deliveries. The epidural rate for vaginal deliveries in Canada is 58.6 percent, Ontario 60.3 percent and Northeastern Ontario 51 percent. The rate of induction of labour in Canada 2013 to 2014 was 21.2 percent. As a result of the medicalization and technological surge, the use of technology during labour and birth has now become the norm.

In Canada, intermittent auscultation of the fetal heart is the preferable technique for intrapartum fetal surveillance in low-risk pregnancies (Liston et al., 2007). Continuous electronic fetal monitoring is recommended for women at risk for adverse intrapartum outcomes (Liston et al., 2007; Canadian Perinatal Programs Coalition, 2009). The Public Health Agency of Canada (2009) published the Canadian maternity experiences survey based on a three month period preceding the 2006 Canadian Census of Population and consisted of birth mothers 15 years of age and older who delivered a live singleton. The survey consists of:

> Canadian women's experiences, perceptions, knowledge and practices before conception and during pregnancy, birth and the early months of parenthood survey for women during pregnancy, labour, birth and postpartum to capture their experiences. (p.11)

The survey revealed that 90.8 percent of women with a vaginal birth or who attempted a vaginal birth reported having electronic fetal monitoring at some time during labour and 62.9 percent reported having continuous use of electronic fetal monitoring. A small percentage of women, 6.5 percent experienced intermittent auscultation of the fetal heart rate during labour by stethoscope, doppler or fetoscope; continuous electronic fetal monitoring was not used at any time during labour (PHAC, 2009).

The essence of a caring relationship between nurse and patient may be lost due to insufficient time, resources and increased technology in health care (Lagana, 2000). Patient care that requires high technological interventions can impede the nurse's ability to concentrate on the interpersonal emotional relationship (Lagana, 2000). The concern with the culture of technology is the devaluing that may be placed on caring and forming caring relationships. Nurses may become distracted or place more emphasis with managing technology than being patient focused. In addition, nurses have become increasingly aware of the professional and legal implications associated with using technology. This alone may affect and impact a caring relationship while providing intrapartum support (Lagana, 2000).

Northeastern, Ontario, Canada Experience

Within Ontario, the North East Local Health Integration Network (NE LHIN) provides health care services for more than 565,000 people, across 400,000 square kilometers (North East LHIN, 2014). There is five sub regions located within the Northeastern Ontario Local Health Integration Network: James and Hudson Bay Coasts, Cochrane, Algoma, Sudbury-Manitoulin-Parry Sound, and Nipissing-Temiskaming. There are 25 hospitals located in Northeastern Ontario, while some parts of Northeastern Ontario are only accessible by air or ice roads (North East LHIN, 2014). Rates of heavy drinking, smoking, obesity and chronic disease are higher than the provincial average. 23 percent of residents are identified as francophone and 11 percent are Indigenous (North East LHIN, 2014). The intrapartum experience for women living in Northeastern Ontario is different than for women living in larger urban centers. More than 40 percent of Northeastern Ontario's population lives in rural areas, in comparison to the rest of the province at 15 percent (North East LHIN, 2014).

The Joint Position Paper on Rural Maternity Care (Miller, Couchie, Ehman, Graves, Grzybowski & Medves, 2012) generated by midwives, nurses, and physicians makes several recommendations for childbearing women who live in rural and remote communities in Canada. There are geographical health disparities that exist among maternal and newborn health such as having to travel greater than two hours to give birth and leaving their community network of friends and family (Miller et al., 2012; CIHI, 2013). Within these varying Northern geographical settings, there may be different needs, availability and accessibility of services for healthcare. Many challenges and barriers exist for Northern communities in accessing healthcare across the continuum of care. Health care services within local communities vary according to availability of health care professionals, resources, infrastructure and technologies. Availability of transportation and travel distance to services may be limited (MOHLTC, 2011).

Maternity care in rural and northern areas is often managed by general practitioners, nurses and midwives (Miller et al., 2012). Some communities may have back up support such as general surgeons, general practitioner-anesthetists, obstetricians-gynecologists and or family physicians with surgical expertise (Miller et al., 2012). General practitioners may be able to accommodate a low-risk pregnancy with local services but may be required to refer high-risk pregnancies to hospitals that have specialized services (CIHI, 2013). There is a lack of health care providers who specialize in offering maternity services, which has led to a decline in services (Miller et al., 2012; CIHI, 2013). According to Better Outcomes Registry and Network (BORN) (2013), from 2011 to 2012 within the Northeast Local Health Integration Network, obstetricians were the predominant care providers attending 70 percent of hospital births. Family physicians attended 15 percent of births in the region and midwives were the most responsible care provider at birth for 15 percent of women who gave birth in a hospital and 13.3 percent of

women under midwifery care had a homebirth. In comparison, across Ontario, 84.7 percent of women had an obstetrician attend their hospital delivery. The proportion of women whose primary care provider was a family physician at the time of their hospital delivery was 8.6 percent. Midwives were the primary care provider for 5.2 percent births in the hospital in Ontario. Caesarean section capability has been shown to strengthen the sustainability of maternity services and is an important factor taken into consideration over the continuation or discontinuance of rural maternity services (Kornelsen, Grzybowski & Isgesias, 2006).

Programs have been developed in response to lack of maternity health care providers to support maternity care and keep women from having to leave their community through the support of midwifery and collaborative community care (Miller et al., 2012). Some programs are based on care provided by registered midwives, registered Aboriginal midwives, and traditional midwives that support birth traditions within the communities (Miller et al., 2012). Implementation of these programs has permitted women to receive low-risk maternity services in their community with positive maternal and fetal results (Miller et al., 2012).

In Canada, hospitalization for childbirth is the most common admission (CIHI, 2018). As a result, women may have to leave their rural communities to travel to a hospital in the closest urban center to give birth (CIHI, 2013). Location can also impact a woman's birth experience and the experience of nurses in providing support during labour and delivery. This may lead to a stressful childbirth experience without the support of their regular pregnancy care providers, family and friends and will impact the importance of labour and delivery support from intrapartum nurses. Most importantly, women who reside in rural and remote communities in Canada should receive quality maternity care as close to their residence as possible. In addition,

maternity care should be collaborative with the woman and her family being at the forefront, as well as culturally sensitive and respectful.

Purpose

The purpose of this qualitative, interpretive description study is to explore the experiences of intrapartum nurses in Northeastern Ontario, Canada, setting and the meaning they place on providing labour support. The research question is: What are the experiences of intrapartum nurses in Northeastern Ontario setting in providing labour support?

Rationale

Qualitative research provides a unique perspective when studying the phenomenon of the meaning of, and experience of the nurse with providing labour support. There is a considerable body of research that identifies the unique position of intrapartum nurses and the role they play in influencing the care and outcomes for women and newborns during labour (Corbett & Callister, 2000; Miltner, 2002; MacKinnon, McIntyre & Quance, 2005; Sauls, 2006; Edmonds, et al., 2017; Sherrod, 2017; AWHONN, 2018). The research question, what are the experiences of intrapartum nurses in providing labour support, was explored to gain an in-depth understanding of the unique capabilities and talents that enable an intrapartum nurse to enhance and create a positive birthing experience for women. The research question guided the research study with intrapartum nurses sharing their experiences of commitment to perinatal nursing and how they support and promote a woman centered birthing experience. The research question is congruent with an interpretive description method that is designed for the discipline of nursing and is meant for the purpose of developing nursing knowledge and to inform clinical practice (Thorne, 2008). Interpretive description makes the assumption that nurse researchers are rarely satisfied with

description alone and are always exploring meanings and looking for explanations that contribute to clinical knowledge (Thorne, 2008).

Significance of the Study

This study is one of the first interpretive descriptive, qualitative research study in Northeastern Ontario in to explore the meaning of, and experience of the intrapartum nurse with providing labour support. This study addressed the gap in nursing knowledge of labour support by looking at the experiences and meaning of labour support through intrapartum nurses. The experience and meaning of labour support was socially constructed around a medicalized discourse that supported a patriarchal role. Historically dominant patriarchal contributions have directly influenced the knowledge development, education, practice, and research endeavors of nursing. Nursing has long been stereotyped as a profession that embodies subservience of women to institutions and patriarchal authority in a traditionally gendered caretaking role (Giarratano, 2003). Nurses are products of a patriarchal culture that historically has viewed men as physically and intellectually superior to women. Nurses are mandated by professional standards to protect the rights of their clients, rights that most nurses would acknowledge encompass the basic rights expressed in feminist philosophy (Giarratano, 2003). Nursing practice should be congruent with the tenets of feminist belief. However, nurses who have been socialized in a patriarchal society may not recognize incongruities in their practice (Giarratano, 2003). Technology challenges the caring relationship between patients and nurses and thus has changed the role for nurses. At the forefront of the discussions, participants described the many challenges of integrating caring behaviours with technological skills. Participants described experiences of barriers and challenges that were not designed to support a woman-centered birth. Participants were passionate and candid in conveying their experience of providing labour

support. They described a spectrum of feelings from immense pride and pleasure, to frustration with a sense of feeling overwhelmed, distressed and sometimes sadness based on barriers and challenges of providing optimal labour support. The findings from this study may be useful to intrapartum nurses who provide labour support in hospitals where less labour support is offered due to high intervention rates. The research findings may lead to an increased awareness and understanding of nurses' relationships with their patients and the value they place on tactile and humanistic skills. The findings may also provide an origin from which to develop guidelines, standards for labour support education or continuing education programs for novice to expert nurses. The findings of this study confirm and demonstrate the multifaceted and significant role that intrapartum nurses play in providing intrapartum labor support to the patient and their family.

Chapter Two: Literature Review

For this literature review, several online databases were utilized. These included Cumulative Index Nursing and Allied Health Literature (CINAHL), OVID Nursing Journals, ProQuest Nursing & Allied Health Source, Academic Search Complete, The Cochrane Database of Systematic Reviews, Google Scholar, Scholars Portal, and manual search in Google. Keywords used included, labour support, intrapartum nurse, perinatal nurse, childbirth, birth, caring during labour, labour and delivery, and intrapartum care. The time frame was not specified. The terms natural birth, normal birth, normal physiologic birth, normal childbirth, and physiologic birth are used interchangeably in the literature. The spelling of labour, as in pregnancy and labour is also spelled as labor. The following topics will be explored in the literature review: labour support conceptualization, evolution of labour support and role of intrapartum nurse, feminism theory, intrapartum nurse and education, benefits of labour support, and technological environment and labour support.

Labour Support

Labour support is a term used by intrapartum nurses to explain the supportive care provided to women during labour and delivery (Sauls, 2006). Multiple definitions of labour support exist within the literature. However, almost all authors agree that labour support is multidimensional and should have a holistic focus. Labour support is a wide-ranging term for providing care and social support provided to families by intrapartum nurses (Davies & Hodnett, 2002; Sauls, 2006). The Association of Women's Health, Obstetric and Neonatal Nurses (2010b) guidelines for professional registered nurse staffing for perinatal units support "a one-to-one RN to patient ratio who have medical or obstetric complications, receive oxytocin, choose minimal intervention in labour, or are in second stage labour" (p.2)

Labour support includes emotional support (continuous presence, reassurance and praise), information about labour progress and advice regarding coping techniques, comfort measures (such as comforting touch, massage, warm baths and showers, promoting adequate fluid intake and output) and advocacy (helping the woman articulate her wishes to others) (Health Canada, 2000; Hodnett, Gates, Hofmeyer & Sakala, 2012; AWHONN, 2018). The Association of Women's Health, Obstetric and Neonatal Nurses outlines labour support as an extensive and comprehensive base of nursing knowledge to deliver a high level of care and support (2010a). The role of the nurse should include the following:

> Assessment and management of physiologic and psychological processes of labour; facilitation of normal physiologic processes; such as the women's desire for movement in labour; provision of physical comfort measures, emotional and information support and advocacy; evaluation of fetal well-being during labour; instruction regarding the labour process; role modeling to facilitate family participation during labour and birth; direct collaboration with other members of the health care team to coordinate patient care. (p. 666)

The Society of Obstetricians and Gynecologists of Canada (Liston, Sawchuck & Young, 2007), report a similar definition to define labour support as:

> The caring work, or social support provided to a labouring woman. It consists of emotional support (continuous presence, reassurance, and praise), comfort measures (touch, massage, warm baths and showers, encouraging fluid intake and output), advocacy (communicating the woman's wishes), and provision of information (coping methods, update on progress of labour). (p. S28)

Evolution of Labour Support and Role of Intrapartum Nurse

Over two centuries ago, residents from France, the British Isles, and other European countries migrated to settle in Canada, and in doing so, this required an adjustment in their way of living (Mason, 1988). One of the biggest adjustments to be made would be that of childbirth. Many settlers had previously come from countries where doctors were regarded as suitable birthing attendants to the middle class. However, now residing in Canada, they would need to change their ways and adapt to the culture of childbirth in their new land and by partaking in traditions such as the sharing of a birth culture amongst family and newfound friends within the community (Mason, 1988). Midwives who evolved from the community birth culture resided in Montreal, formally Ville-Marie were chosen by women of the community and provided a wage by the French king from the beginning of the eighteenth century until approximately 1759 (Mason, 1988). Midwives residing in Nova Scotia were provided a wage from the British government. At this time, midwives did not receive the recognition and support deserved across the vast land of Canada and the wages were not enough to meet their cost of living (Mason, 1988).

The practice of midwifery constitutes the oldest, most traditional, and culturally widespread care for women during childbirth (Connor, 1955). Midwives have been the traditional caregivers at births and have long cared for First Peoples of North America for thousands of years before. Midwives are a respected part of settlements in colonial Canada who have attended births and provided healing (Burtch, 1994). A quote from Burtch (1994)

> Midwives were in demand among the settlers in Nova Scotia, for in 1755 a request came from Colonel Sutherland, in command at Lunenberg, for two proper persons to reside

there as midwives at a salary of two pounds a year, as the inhabitants were losing so many of their children. (p.18)

The new settlers soon came to realize that they would need to take care of one another during childbirth in Canada (Mason, 1988). Supporting women through childbirth was a community event. A midwife, known as a woman with extra skill and experience, aided in childbirth along with female relatives, friends and neighbors. All the women would work together to provide support in the household and lend a hand with chores on the land (Leavitt, 1986; Mason, 1988). There was no special training or apprenticeship for the midwife, only the participation of attending upwards of 60 to 90 births in their lifetime (Mason, 1988). Because of the vast Canadian land and often a large distance between homes, many attending female relatives and friends stayed for days or weeks during the "lying-in-period" as the woman made the transition to being a mother (Leavitt, 1986; Mason, 1988). Neighborhood women, friends and female relatives attended the childbirth as part of their contribution to the community with the expectation that the labouring woman would one day reciprocate (Wilson, 1996). An excerpt from Mary O'Brien's journal that lived north of York (Toronto) and kept a journal from 1828 to 1838 on the births she attended (Mason, 1988):

> I mean, we didn't know exactly when a baby was going to be born, but when you were there, you just didn't feel like leaving. The mother was reassured when you were with them, you know. And you weren't always doing a lot of work all the hours previous to the birth of the child, but you were doing anything you could to allay fears, perhaps for a young mother with her first child. They had to be comforted. And you know, just the little things – if you only rub their back a bit or things like that, they'd help a bit, you see? (p.101-102)

Religious nursing orders spread throughout Quebec and across Canada in the early 1600s until the 1900s, providing care for people in their homes and establishing networks in hospitals (CNA, 2008). The Grey Nuns, the Sisters of Providence and the Religious Hospitallers of St. Joseph continued with a successful apprenticeship system originating from France and Europe. In English Protestant Canada, modern nursing began with the "Nightingale" system of nursing training in the early 1870s. Prior to the development of training schools for nurses, nursing care in the hospital was performed by both skilled and unskilled workers (CNA, 2008).

Progressive acceptance of the germ theory of diseases, the discovery of the causes of diseases and advancements in surgical and anesthetic techniques all had a major influence on the development of hospitals and the quality of care provided. In the late nineteenth century, hospitals continued to provide care for the impoverished but they focused their attention on middle and upper class society who were impressed by modern scientific advances (CNA, 2008). Hospital administrators and physicians enticed patients through promoting medical technology and trained nurses, both of which were advertised to lead to better care and outcomes (CNA, 2008). During the 1890s nursing activists attempted to separate themselves from being linked to domestic labour through identifying themselves as "graduates of recognized hospital training schools as professional workers" (Connor, 1955, p. 20).

Mason (1988) tells the story of Myra Bennett, a nurse, working in an outpost community station in Labrador who found herself participating in the "female activities" supporting childbirth. Myra recounts cooking up a huge pot of rabbit stew to augment a woman whose labour was slow and she was running out of energy. The symbolism of the preparation of food was often viewed as a gift and frequently used in the birth culture (Mason, 1988). While most births held a "non-interference" approach, interventions or what were known as folk remedies

may be administered to avert a crisis (Mason, 1988). Women often worked hard performing chores on their land and thus a woman who was pregnant would remain physically active until her labour begun and would be advised to eat an abundant amount of good food (Mason, 1988). A second stage failure would render a midwife who would place "cayenne pepper into a hollowed-out goose quill and blow it into the nose of woman who seemed to be making no progress pushing her baby out" (Mason, 1988, p.105). This intervention would result in the woman sneezing and subsequently bear down in an effort to push out her baby. Cases that were acute emergencies such as eclamptic seizures, breech presentation or cephalopelvic disproportion would require immediate interventions by the doctor or midwife (Mason, 1988). Doctors at this time had access to special instruments and chloroform to sedate the mother, while the midwives did not and consequently were only permitted to provide care while the woman was awake (Mason, 1988).

In 1795, the first law regulating medicine in Upper Canada made specific mention of midwifery and an attempt at preventing women from receiving support during childbirth (Connor, 1955, p.107) "no person…shall be permitted to vend, sell, or distribute medicines by retail, or prescribe for sick persons, or practice physic, surgery or midwifery within the Province, for profit, until such persons or persons shall be duly approved by a board of surgeons." Most midwives were not receiving a wage but instead an exchange of goods and food for their services. Consequently, this law had minimal impact to restrict the practice of midwifery within the province. Over the course of the next 65 years, midwives would face resistance from the government and in 1865, the Medical Act, would deem female midwifery illegal, although without specifically identifying restrictions to midwifery. Accordingly, midwives would continue to practice legally, although in a grey area (Connor, 1955).

Maternal mortality reports investigating medically underserviced areas in Canada surprised investigators with unexpected results (Mason, 1988). In 1919, Saskatchewan's Medical Officer of Health reported that 50 percent of the women who gave birth without either a doctor or nurse in attendance had a much lower maternal mortality than the other 50 percent (Mason, 1988). Comparable results in Manitoba in the 1920s and in 1928, the Red Cross in Ontario divulged that the maternal mortality was higher in hospitals than in medically underserviced areas (Mason, 1988). At the turn of the century, when the birth culture was still very prevalent, there was an increasing desire in the superiority of medical births. Accordingly, those with medical background observed a disregard for traditional birth culture.

Towards the end of the nineteenth century as Canada's population grew through immigration, and the number of doctors increased, discord between midwives and physicians occurred (Mason, 1988). With a government connection, physicians attempted to prevent midwives from practicing and making the birth culture illegal (Mason, 1988). However attempts to do so would be met with resistance. Persuasion of the dangers of a non-medical birth was being displayed in articles in magazines and public statements by doctors were being made (Mason, 1988). A proclamation by doctors stated that childbirth needed to be managed by a doctor who had special training. The formation of the Victorian Order of Home Helpers, by the National Council of Women of Canada, would offer training to the neighborhood women mainly in midwifery but also in first aid, basic nursing, and household economy and sanitation (Mason, 1988). The members of the National Council of Women planned to connect the traditional birth culture with the promoted benefits of medical obstetrics. The National Council deemed nurses to be unsuitable maternity assistances because they were compelled to follow rules and routines. Mason (1988) "the need was…for a practical woman who has some training and will go from

house to house doing all sorts of mercy and kindness, rather than the nurse selected to go to a certain place to attend a certain case" (p.107).

With the intention of the National Council to provide childbirth training as suggested by the doctors, medical resistance was united (Mason, 1988). Trained nurses also provided resistance stating that their training should permit them as the only assistants to doctors (Mason, 1988). In 1897, Lady Aberdeen, wife of the Governor-General established the Victorian Order of Nurses of Canada and planned to include trained midwives (Cross, 2014). Medical opposition was faced once again for fear that women giving birth would prefer the services of nurses and midwives over those of physicians (Mason, 1988; Cross, 2014). An active campaign by the Ontario Government would continue to promote safe, scientific, and modern physician-attended births for expectant mothers (Cross, 2014). Lady Aberdeen taking matters into her own hands, requested assistance from American physician Dr. Alfred Worcester, who operated the only non-hospital training school for nurses in North America (Mason, 1988). Dr. Worcester encouraged the Council of Women to remove the use of midwives and to promote the nurse as under the authority of the doctor who would carry out their orders and reduce their workload. Dr. Worcester would seek support from medical societies over eastern Canada and would eventually receive support (Mason, 1988). In 1898, the Victorian Order of Nurses was allowed to begin performing nursing in the impoverished urban areas. With an increasing number of doctors desiring to play a role in childbirth, some doctors were forced to receive training from traditional birth helpers due to the minimal amount of obstetrical training received. Doctors would not receive obstetrical training until after the First World War (Mason, 1988).

In 1927, the national maternal mortality rates continued to be low and doctors declared they had barely used forceps, disinfects or any of the mainstream obstetrical drugs (Mason,

1988). In the 1930s in Ontario, the majority of births occurred in the home delivered by doctors or midwives (Cross, 2014). Relationships were strained when a new doctor presented themselves to the community and refused to conform to the practices within the community (Mason, 1988). Some women preferred the traditional birth culture thus causing financial suffering for physicians along with underuse of clinics and hospitals. Trained nursing groups attempted to convince women to transform to the "safe" medical birth (Mason, 1988). However, hospitals based on a financial decision, chose not to hire back nurses instead deciding to utilize free student labour (Mason, 1988). Some nurses chose to move into a new field of nursing called public health nursing (CNA, 2008). The public health nurses who worked autonomously were provided with a government salary and offered care to pregnant women and sick people in their homes (Mason, 1988; Cross, 2014). The public health nurses faced opposition from doctors who expressed that nurses working outside of hospital supervision might infringe on medical privileges (Mason, 1988). Dejectedly, doctors restricted the nursing and childbirth care and as a result nurses were labeled with performing a health-teaching role (Mason, 1988). Nurses reacted by seeking the approval of doctors by becoming activists for doctor-assisted births. Nurses tirelessly campaigned and advertised with pamphlets and information, all the while discrediting the role of the midwife (Mason, 1988). An excerpt taken from a federal government publication entitled *The Canadian Mother's Book* (Mason, 1988):

> The doctor will relieve you of pain as much as possible and will stay with you till you are quite safe. If this is not your first baby, it may take more than one or two hours. Everybody will take care of you. The doctor and nurse will take charge of everything for you, till you and the baby are quite safe. And then you will have a good rest until you get your strength back. (p.111)

In 1940, *The Canadian Mother's Book* sold over one million copies before it was replaced with a second edition. Radio advertisements emphasized that doctors should be taking over and providing a medical birth. Dr. Roy Dafoe, a physician from Northeastern Ontario, who won the Nobel Prize in medicine for delivering the Dionne quintuplets, provided a radio announcement (Mason, 1988):

> During pregnancy: It is not necessary for me to remind you again that this is a time when you must place yourself unreservedly in the hands of your medical advisor, and when the best help you can give will be in the spirit of complete submission and co-operation. Remember that the various measures you will be asked to take are essential for your welfare and for the safety of your baby. The doctor knows by experience (and his own skill is backed up by all the accumulated wisdom of his profession) just what to do for you. (p. 112)

The relentless message advocating for medical births demonstrated steady deflation of women's self-confidence in their own birth culture (Mason, 1988). Middle-class women were choosing to give birth in the hospital. However, the hospital was not a place for traditional birth culture to occur. Few doctors would provide medical help in the community but not without demanding payment up front (Mason, 1988). Women responded by calling on the government to help to send doctors to provide medical care. In rural areas, doctors were unable to make an adequate income and thus did not stay (Mason, 1988). As a result, nurses sent by the Red Cross, the Victorian Order of Nurses and provincial health departments on government salary provided care but all the while advocating for medical births (Mason, 1988). Some nurses were actually British trained midwives but did not disclose this (Mason, 1988). Many nurses provided midwifery services labeled as "maternity nursing" in rural, remote and poor urban settings to

women who were too poor or opposed to use doctors. Many of the women had minimal prenatal care and lived in poverty, however the birth mortality rate was routinely less than half the birth mortality rate of the general population (Mason, 1988).

In Canada, the hospital birth mortality rate was higher than home births. Two American reports published that maternal mortality had not declined between 1915 and 1930 despite the increase in hospital deliveries, prenatal care, and aseptic technique (Mason, 1988). And even more alarming, was that infant deaths from birth injuries had increased by 40 to 50 percent from 1915 to 1929 (Mason, 1988). Canadian medical journals found these statistics to be applicable to Ontario and Quebec (Mason, 1988). Obstetricians became concerned about the obstetrical interventions that were being used and decided to improve obstetrical teaching and procedures and include obstetrical teaching in Canadian medical schools.

During this time, there became a focus of the birthing woman and her family. Hospitals, in an attempt to decrease mortality rates from puerperal fever, placed strict guidelines on women. Labouring women would be kept apart from family and friends, and nurses were required to "degerm" the woman and her environment (Mason, 1988). Women were required to be have their cervix examined under aseptic technique and were also required to be shaved, douched, swabbed and stool evacuated. The woman was not to touch her lower body and would be required to wear a mask if she was ill (Mason, 1988). To ensure strict infection control, the woman during the later part of her labour and delivery would have her wrists tied down (Mason, 1988). Fathers were not included in the labour and delivery process and were forced to wait in the waiting room. This impersonal experience left women feeling ignored, threatened, and criticized.

The widespread land of Canada prevented traditional birth culture and midwifery to go away, instead *The Canadian Mother and Child* included a chapter on delivering babies without medical attendance (Mason, 1988). Birth culture and informal midwifery were still very much being practiced to support those women during childbirth without medical attendance (Mason, 1988).

Around 1937, there was a decrease in maternal mortality rates from puerperal infection in Europe and North America (Mason, 1988). This coincided with the advent of the first antibiotic in Canada. In Canada, hospital birth mortality rates were parallel to home births. Consequently, home birth mortality began to increase each year (Mason, 1988). Subsequently, home birth declined rapidly (Mason, 1988; Cross, 2014). By 1950, less than ten percent of birth took place in the home (Cross, 2014).

However, in the northern part of Canada and in the North-West Territories, most communities believed that non-medical births were unnatural. However, many communities had large groups of women well known as midwives (Mason, 1988). The native birth culture was reflective of a high-level of skill among women and midwives helping out during births. A campaign by the Canadian government sought to increase northern nurses and physicians in an effort to combat active tuberculosis (Mason, 1988). Once recruited, doctors and nurses would be expected to increase their practice to include childbirth (Mason, 1988). The nurses attempted to convince women to deliver their babies at nursing stations and also offered prenatal care together with vitamins and food supplements (Mason, 1988). In the 1960s, the Canadian government endeavored to recruit midwives from Britain, New Zealand and Australia to work in northern Canada (Mason, 1988). Throughout 1940 to 1960, proclaimed childbirth academic experts such as pediatricians, obstetricians, and child psychiatrists became activists for early contact between

newborns and their mothers (Phillips, 2003). In 1960, family-centered care was devised to include the father in childbirth preparation classes and in the birth itself (Phillips, 2003). Mothers and newborns were permitted to room-in together in one room with the mother providing care of the newborn. The theory behind this was to prepare the mother for taking her newborn home (Phillips, 2003).

Fifteen years later, a gradual reduction in nursing stations required women to be sent out of their community, away from family and friends and sent to a distant hospital for safe childbirth (Mason, 1988). This decision was based solely on hospitals being the safer place to deliver (Mason, 1988). By 1970, all women would be shipped to a hospital for delivery (Mason, 1988). The decline in births at the nursing station also ensued a decrease in skill competency (Mason, 1988). Accordingly, Canada's plan to create a safe midwifery system across the north had failed (Mason, 1988).

The birth culture in the 1970s and was unique and reintroduced many changes. There was increased interest in avoiding hospital birth and home births again began to rise (Mason, 1988). Some doctors supported this new trend, while others criticized birth at home. Sauls (2000) reports these changes were largely in part to the feminist movement and the demand for labour support leading to maternal satisfaction and reduced labour length. Birth styles and practices varied and reflected the wishes of women and their families (Mason, 1988). Once again, an increased demand for midwives and birth culture involving friends and family supporting and helping one another out during labour reappeared (Mason, 1988). However, very few midwives at this time had formal training, however, participated in extra training through workshops and courses. Prenatal care would occur at intervals and was usually informal. The traditional birth culture practices that involved friends attending with the midwife, while

cooking, cleaning and caring for any other children was occuring (Mason, 1988). Feminists advocated for the role of the midwife to be dominant in the birth culture.

Continuing into the 1970s intrapartum nurses continued to advocate for fathers to be part of the childbirth process and for birthing rooms to be introduced (Sauls, 2000). The emphasis continued on becoming family-centered care, shifting the focus from individualized-care. Women complained resentfully about having their babies taken away from them following delivery (Phillips, 2003). Babies were placed in a nursery staffed by nurses and mothers were encouraged to rest. Families were requesting increased involvement and less separation following birth. This change led to a more holistic role for the intrapartum nurse, not just focusing on the physical aspects of care (Phillips, 2003). Technology known as electronic fetal monitoring was introduced to begin monitoring mothers during labour and birth (Wertz & Wertz, 1989). Previously, a baby was monitored by using a fetoscope, or doppler ultrasound to detect the baby's heart rate (Healen, 2013).

During the 1980s to 1990s, a shortage of health care providers in Canada provoked the maternity care crisis (Kornelsen, 2003; Rogers, 2003). In 1990, Canada was considered to be one of the safest countries in the world to give birth (Kornelsen, 2003). It was ranked sixth in infant mortality and second in maternal mortality. By 2006, Canada declined in its standings and was ranked 21st for infant mortality and ranked 11th for maternal mortality (Kornelsen, 2003). In 2003, less than half of the family physicians were offering maternity care to their patients and an anticipated retirement of obstetricians without replacement would further lead to the decline of maternity care to patients (Kornelsen, 2003; SOGC, 2008). Accordingly, this shortage led to a growing concern about Canada's ability to provide adequate care for pregnant women and their babies (Kornelsen, 2003). Rural and remote areas of Canada continued to be affected by the

shortage of health care providers with family physicians and registered nurses providing care (Rogers, 2003). However, rural hospitals faced challenges of attracting and retaining maternity care providers with experience. Additionally, sustaining skills in hospitals with low birth rates could lead to loss of confidence and burnout due to additional on-call responsibilities (Rogers, 2003). Also during this time, there was limited access to midwives (Kornelsen, 2003). Midwives were only permitted to practice in four provinces. Of the 400 midwives registered to practice in Canada, midwives attended only two percent of total births (Kornelsen, 2003).

During 1980s and into the 1990s, hospitals were required to cut costs and accordingly, new models of care were created to be more functional and homelike (Phillips, 2003). These models of care were (LDRs) labour, delivery, recovery rooms and postpartum units with separate nurseries for newborns. Some hospitals created (LDRP) rooms, labour, delivery, recovery, and postpartum rooms with a separate room known as a nursery where babies could be observed if necessary (Phillips, 2003). The purpose was to keep both the mother and newborn together in the room following the birth. In order to do so, nurses were trained to work in labour and delivery as well as care for the postpartum mother and her newborn (Phillips, 2003).

Well into the 1990s, a rise in medicalization of the labour and delivery experience to make childbirth safer (Sauls, 2000). While women were labouring in a birthing room, they were attached to a fetal heart monitor, receiving oxytocin through an intravenous to augment their labour and receiving epidural anesthesia for pain management (Sauls, 2000). With increasing medical interventions came the risk for legal liability. Assessment of electronic fetal monitoring is integral to labour management, and many legal challenges are based on interpretation and actions taken on the basis of fetal surveillance data. Accordingly, it is essential that nurses be

competent in using this technology (Zwelling, 2008). Currently, the goal still remains much the same, for a safe labour and delivery and this is symbolized through the use of technology.

In the twenty-first century almost all women are still giving birth in hospitals (CIHI, 2017). In 2013, there were 380,233 babies born in Canada, of those births, 372,850 delivered in a hospital. The latest data from Statistics Canada (2016) indicates 392,902 babies were born in Canada from 2015 to 2016, and of those, 3,513 births took place in Northeastern Ontario (CIHI, 2017). A steady incline has been noted each year in Canadians giving birth. Pregnancy and childbirth remain the leading causes of hospitalizations among Canadian women, and caesarean sections are the leading cause of inpatient surgeries (CIHI, 2018).

Feminism Theory and Intrapartum Nursing

When discussing the evolution of intrapartum nursing, it would be amiss not to recognize the contribution of feminist theory. Historically, childbirth is an experience that is embedded in unequal power between women and their medical caregivers (Malacrida & Boulton, 2013). The evolution of childbirth changed from a woman-centered home event to that of a hospital-centered medical and technical event. Many feminists agree that medical dominance over all aspects of childbirth has weakened women's control and autonomy over their bodies and the childbirth process (Malacrida & Boulton, 2013). The history of childbirth and the construction of women's experiences has been written, shaped and directed by men. The feminism paradigm is based on philosophical and theoretical views of women and their place and role within society (Tong, 2009). Feminism is a theoretical belief that appreciates the diversity, trends, issues and continuing evolution of women (Tong, 2009). Feminism provides a prospective to viewing what woman-centered care during labour should represent. There is a culture that nurses are subservient to the obstetrician and this notion is also portrayed to the patient. A feminist

perspective of birth alters the balance of power, as it focuses on women-centered care, and supports women remaining in control of their birth experience. Within feminist literature, there is evidence that aspects leading to the medicalization of birth have been created on a gender perspective bias (Behruzi, Hatem, Goulet, Fraser & Misago, 2013). As a result, it is believed that this patriarchal construction of childbirth has contributed towards modern medicine and obstetric technology causing a shift of normal physiological birth to that of a pathological process (Brubaker & Dillaway, 2009; Behruzi et al., 2013). Accordingly, there are multiple viewpoints, beliefs and definitions of feminism. Behruzi et al. (2013) suggest that the essence of feminism theory concentrates on women-centered care during childbirth that ensures respect for values, beliefs, autonomy, choices and control over their bodies as part of a humanized birth. Humanization of childbirth is opposing to the predominant medical and technological model (Behruzi et al., 2013). Many beliefs of feminist thinking exist; however for the purposes of this discussion only first wave, second wave, and third wave and their relevance to childbirth will be considered.

Throughout the nineteenth and twentieth centuries, the first wave feminists fought for women's rights to include control over their bodies and decision making with choices in childbirth and reproductive life (Beckett, 2005; Brubaker & Dillaway, 2009; Behruzi et al., 2013). At the turn of the twentieth century, there was a shift from home births under the care of the midwife, to the hospital under the supervision of the physician. Feminist activists suggest physicians capitalized on hospital births as an opportunity to portray childbirth as a dangerous, pathological event and to devalue the holistic care of the midwives. Access to pain relief was demanded by the first wave of feminist activists as a woman's right. As a result, women were

granted the right to relieve their suffering and have the right to accept or decline the use of pharmaceuticals (Beckett, 2005).

Second wave feminism took the opposite position of the first wave in the late 1960s and early 1970s and became interested in a natural birth that was female controlled and once again advocated for home births under midwifery care (Beckett, 2005). The 'natural birth' or 'alternative birth' movement supported a more humanistic, woman-centered and holistic approach to childbirth (Behruzi et al., 2013). The alternative and natural birth movements advocated for treating childbirth as an important life event involving family rather than a medical emergency with "…the inhumane and impersonal nature of many routine hospital procedures" found in the medical and technological approach to childbirth (Beckett, 2005, p254). Women often demonstrated an altered body image and a feeling of powerlessness giving birth under medical ideology of the physician and being directed to follow their instructions (Brubaker & Dillaway, 2009). Use of the electronic fetal monitor emphasized more on the needs of the fetus than the labouring woman (Brubaker & Dillaway, 2009).

The third wave of feminism also known, as contemporary feminism has emerged revalidating a woman's right to choose a technological and pain free birth rather than a natural one without analgesia (Behruzi et al., 2013). Contemporary feminists suggest that technology is not necessarily a male-gendered machine representative of the obstetrician's authority at birth but one that women desire to meet their needs and serve a purpose (Behruzi et al., 2013). Accordingly, women can purposefully choose and benefit from the utilization of technology during childbirth (Beckett, 2005). The movement of third wave feminism acknowledges women's childbirth experiences are based on differences in ethnicities, nationalities, religions

and cultural backgrounds that play a role in their decision making with respect to a medical and technological birth (Behruzi et al., 2013).

Within obstetrics the term women-centered has been used to describe birthing environments, however, these environments have yet to endorse practices and interventions resembling woman-centered care (Goldberg, 2002; Brubaker & Dillaway, 2009). A women-centered approach to birth is described as one in which a birthing "woman is central to her own birth, not only because it is her physical body that births the baby, but also because the woman herself is a dynamic participant in her birth" (Goldberg, 2002, p.103). Goldberg (2002) portrays women-centered birthing as a "lived, experiential, and embodied practice" (p.103). Goldberg (2002) describes women-centered birthing as actualized when there exists a relational engagement that is directed from nurse to woman, woman to nurse, and between and among the nurses providing care.

Kitzinger (2015) advised "If you really want to help a woman in labour, try not to manage, conduct or coach. What she needs far more is someone to help boost her strength and confidence" (p.2). When health care providers attempt to manage birth, there is a loss of control and subsequently, a sense of power in choice and decision-making (Katz Rothman, 1996). Childbearing women are generally healthy and capable of making decisions related to their care. The birth setting is a specialized environment wherein childbearing women plan for the birth of their baby and desire to be an active participant in the process (Simmonds, 2008). Nevertheless, childbirth often has an unpredictability aspect and some women may face disappointment when choices are unavailable or caregivers are reluctant to respect these choices (Simmond, 2008). The relationship that forms between an intrapartum nurse and a labouring woman is unique. In a short period of time a relationship that is based on establishing rapport and trust endures together

in an embodied experience that ends with a extraordinary journey: the birth of a baby. A positive labour and birth experience that results in a healthy newborn is a focus and concern for intrapartum nurses. Similarly it is also a concern mother's share as well.

Intrapartum nursing care is a practice that is designed to foster the health and well being of women to help create a positive birth experience (Golding, 2003). A positive childbirth experience is linked to many benefits for both the mother and newborn. It is the perception of the childbirth experience that stays with a woman and creates a permanent imprint within her life. Simkin (2002) reports that women who received supportive care during their labour and delivery were able to recall 15 to 20 years later the specific words and actions of their nurses. The women who remember their nurse as being kind, supportive and offering comfort measures acknowledged a positive childbirth experience. The type of support a woman receives can make a difference in whether she remembers her experience as being disembodied or as one that enhances her feelings of self-worth and self-esteem (Golding, 2003).

Golding (2003) denotes expert perinatal nurses must demonstrate a commitment to respect the decision-making and self-direction expressed by labouring women. Failure to do so may result in women feeling exploited and not supported with their birthing plan. Intrapartum nurses should endeavor to demonstrate "commitment to facilitation, not exploitation" (p.581). Facilitation is enacted by intrapartum nurses when women in labour are provided with information and choices and allowed to make decisions with respect to their labour such as positions and ambulation, comfort measures, and the use of medical interventions such as oxytocin. Goldberg (2008) purports perinatal nurses exemplify the ability to advocate and demonstrate respect for autonomy within the practice setting. The concept of advocacy and autonomy support an individualistic belief, views and personal choices (Simmonds, 2008).

However, Goldberg (2003) challenges this conception by suggesting that women are not able to make an autonomous informed decision because of already determined policies and procedures over which women have no control. She further suggests that these protocols leave minimal choices for women and that the expert opinions are valued more than the input from the woman herself. Therefore, nurses may perceive themselves restricted in their ability to advocate and support autonomy. Despite this, intrapartum nurses endeavor to empower and respect a woman's birthing plan and willingness to facilitate the birth. As expressed by Patricia Benner (2000):

> Nursing practice invites nurses to embody caring practices that meet, comfort, empower and advocate for vulnerable others. Such a practice requires a commitment to meeting and helping the other in ways that liberate and strength, and not ways that impose the will of the caregiver on the patient. (p.11)

Intrapartum Nurse and Education

The College of Nurses of Ontario (CNO) is the regulatory body for registered nurses in Ontario. CNO outlines practice standards and competencies that all registered nurses are held responsible and accountable to. The core perinatal nursing requirements include current certification from relevant professional College of Nursing; knowledge and skill in supportive care for labour, birth, and breastfeeding; skills and knowledge related to physical and psychosocial risk assessment. Further requirements and certifications for providing nursing care are then specified according to the institution at which the nurse is employed.

Canadian Nurses Association (2017) describes perinatal nursing as providing care throughout the childbearing continuum from preconception to three months after birth. The goal of perinatal nursing is to provide for the safety and well being of the woman, her family, and

fetus to newborn. Perinatal nursing practice includes care for women, newborns, and families throughout preconception, antepartum, intrapartum, and postpartum period. For the purposes of this study, intrapartum nursing care will be the focus.

The Association of Women's Health, Obstetric and Neonatal Nurses (2009) in the document *Standards for Perinatal Nursing Practice and Certification in Canada* define the nurse's responsibility to women and newborns. The Standards of Professional Performance describe the many roles and behaviours that the perinatal nurse is accountable for together with measurement criteria outlined with each standard. The Standards are to be used in collaboration with Standards from the Canadian Nurses Association, provincial nursing associations, the Association of Women's Health, Obstetric and Neonatal Nurses evidence-based clinical practice guidelines, health care facility guidelines and Canadian law and regulations. Education is detailed as "the registered nurse acquires and maintains knowledge and competencies that reflect current evidence-based nursing practice for women and newborns" (p. 10).

The Canadian Nurses Association offers registered nurses who are practicing in the specialty of perinatal nursing to write a comprehensive exam. The voluntary certification in perinatal nursing is one way that nurses can demonstrate their competence in providing care for childbearing women and their newborns. The exam competencies include preconception, antepartum, intrapartum and postpartum.

The Role of the Intrapartum Nurse in Labour Support

Women's birth experiences are strongly influenced by intrapartum nurses and their support and comfort measures. Childbirth experiences are enriched when women feel supported, respected, and valued (Bowers, 2002; Carlton et al., 2009). Intrapartum nurses have the most contact with families in hospital during labour and delivery and are present at almost all births

(Bryanton, Fraser-Davey & Sullivan, 1993; Barret & Stark, 2010; Liva et al., 2012). Nurses while providing one-to-one care with labouring women have an important influence on the outcome of their labour and delivery experience. It is often the intrapartum nurse that is the deciding factor in whether the woman has a negative or positive experience during their labour and delivery (Bryanton et al., 1993; Simkin, 2000). Davies & Hodnett (2002) recognize there is a disparity between clinical practice guidelines that recommend nurses provide one-to-one labour support and the amount of time nurses are actually providing support. This is largely in part to intrapartum nurses spending more time managing technology than providing comfort and support during labour (Davies & Hodnett, 2002; James, Rice Simpson & Knox, 2003; Romano & Lothian, 2008; Payant, Davies, Graham, Peterson & Clinch, 2008; Liva, Hall, Klein & Wong, 2012).

Benefits of Labour Support

Society of Obstetricians and Gynecologists (2007) recommend that women in active labour have continuous one-to-one labour support acknowledging that the nurse is caring for two patients, the labouring woman and her fetus/newborn. Similarly, Association of Women's Health, Obstetric and Neonatal Nurses (2011, p.665) states, "continuously available labour support from a registered nurse (RN) is a critical component to achieve improved birth outcomes." Continuous labour support promotes patient safety.

Researchers examining the effects of labour support have shown positive outcomes for women and their babies. Hodnett et al., (2012) in an ongoing database of systematic reviews in the Cochrane Database, first published in 1995 and more recently updated in 2012, demonstrated the benefits of continuous labour support. The systematic review of 22 studies from 16 countries, including more than 15,000 women, reviewed the effect of continuous, one-to-one intrapartum

support compared with usual care and if continuous labour support was affected by routine practices and policies, the provider's relationship to the hospital and woman, and time of onset of labour support. The review looked at labour support being provided by hospital staff and non-hospital staff. Hospital staff included nurses and midwives, and non-hospital based staff included personnel such as having a personal relationship to the labouring woman or companions. The results of the review determined that continuous labour support was associated with decreased use of intrapartum analgesia, decrease use of regional analgesia/anaesthesia, decreased operative vaginal deliveries, decreased caesarean births, increased spontaneous vaginal births, and reduced likelihood of reports of negative experiences.

A significant finding by Hodnett et al. (2012) reported the advantages of continuous labour support appear to differ by provider. Continuous labour support by hospital staff reflected limited effect as a result of experiencing additional tasks besides providing labour support, constraints of organizational practices and policies and routine practices. Accordingly, non-hospital staff such as continuous support from a person who is present merely to provide support and is not a member of the woman's social network but has experience and training in providing labour support appears to be most helpful. As a result, non-hospital staff demonstrated more effective labour support as they had no additional responsibility to anyone other than the woman. Hodnett et al. (2012) expresses concerns for nurses and midwives to offer effective continuous labour support in the context of current birthing environments as a result of concurrent responsibilities, devoting a large amount of time managing technology, documentation, length of shifts, and may lack labour support skills or work in short-staffed environments. Despite the evidence and recommendations for continuous labour support, researchers have discovered in an exploratory survey that intrapartum nurses are only spending 25.1 to 27.8 percent of their time

providing labour support (Payant, Davies, Graham, Peterson & Clinch et al., 2008). Liva et al. (2012) in a secondary analysis of a cross-sectional survey report that increased interventions in childbirth have been a factor in contributing to negative psychological outcomes, such as post-traumatic stress disorder. MacKinnon et al. (2003) in an exploratory study acknowledge that women describe the presence of the intrapartum nurse as an important part of their childbirth.

Notwithstanding the many benefits of continuous one-to-one labour support, intrapartum nurses encounter many challenges and barriers upholding this recommendation. With increased rates of inductions and caesarean sections together with increased obstetrical morbidity and associated complications, nurses are providing care for higher acuity women (Hodnett et al., 2012). Accordingly, nursing care requires more consideration to technology and documentation. In addition, the Institute for Safe Medication Practices (2014) states two frequently used medications, oxytocin and magnesium sulfate, are regarded as high-risk medications and therefore require intensive administration safety measures, continuous maternal and fetal monitoring and ongoing assessments. The administration of high-risk medications and the use of technology should require the nurse to be present in the patient's room and thus providing labour support simultaneously, however that is not the case. Graham, Logan, Davies and Nimrod (2004) in a qualitative case study suggest that intrapartum nurses who are supporting and managing labouring women in technologically and stressful situations to ensure patient safety, may perceive labour support as being a secondary priority since it does not place the woman at risk.

Technological Environment and Labour Support

The focus of care has shifted from no to minimal interventions with labour and delivery to one with associated high-technology interventions (Romano & Lothian, 2008). Nursing

students and novice graduating nurses depending on their clinical experience may not have had the opportunity to view a labour and delivery. With that being said, the change to high-technology labour and delivery is a comfortable transition for many new nurses (Zwelling, 2008). Huntly as cited in Zwelling (2008) proposes that new nurses are a part of an iGeneration, as they were born into the era of technology and that is what they are most familiar with. Thus, a technological managed labour and delivery that can be quick and effective such as a patient receiving epidural anesthesia and oxytocin augmentation is not a negative concept but rather an easy solution. As a result, nurses today have not learned labour support strategies, and are uncomfortable providing this type of care, or may have no mentors or role models from which to learn hands on labour support and comfort measures (Sleutel, Schulz & Wyble, 2007).

Glenn, Stocker-Schneider, McCune, McClelland & King (2013) define caring nurse practice as a model for nurses that encompass caring nursing practices of advocacy, education, nurturing care and support that meets the holistic needs of patients who are involved in complex technological tasks. Nurses are required to navigate the complexity of balancing labour support together with technological tasks (Glenn et al., 2013). Traditionally nurses use a variety of knowledge, skills, instruments and tools to meet the needs of patients. In the formative years of nursing, knowledge was ascertained through kinesthetic learning, trial and error, and wisdom passed down from one generation of nurses to another (Hoerst & Fairman, 2000). As nursing sought to become a professional organization, the demand for a scientific-based body of knowledge became essential (Hoerst & Fairman, 2000). The twentieth century featured many scientific and technological changes for nursing. In the 1970s, electronic fetal monitoring was introduced and contributed to a shift in obstetrics that was primarily low technology to now technology dependent (Hoerst & Fairman, 2000). Electronic fetal monitoring became standard

practice in obstetrics and was used despite lack of evidence and concerns of a machine being part of the birthing process (Hoerst & Fairman, 2000). The perceived benefits of electronic fetal monitoring by practitioners and patients were that it provided prompt findings of abnormal fetal heart rate tracings through a steadfast and objective scientific machine. The use of electronic fetal monitoring provided a rationale for an increased cesarean section rate, enlarged health care costs, and over-medicalization of a normal birth (Hoerst & Fairman, 2000).

Attention to managing technology has separated the nurse from being with the labouring woman and providing therapeutic hands-on care and assessing maternal labour progress and fetal well-being (Hoerst & Fairman, 2000). Some hospitals have introduced the use of central fetal monitoring as an adjunct to continuous electronic fetal monitoring (Heelan, 2013). There is an assumption with the increased use of fetal health surveillance; it will improve perinatal outcomes (Heelan, 2013; Brown, McIntyre, Gasparotto & McGee, 2016). The central fetal monitoring station is placed at the nursing station to permit nurses and obstetricians to observe multiple patients simultaneously. This then permits nurses the ability to oversee a labouring patient on a monitor at the desk, and in turn consequently reduces the amount of time spent at the bedside.

Intrapartum nurses have been greatly impacted with the transformation of care provided during the intrapartum period with the use of technology (Hoerst & Fairman, 2000). Electronic fetal monitoring has altered the scope of practice for intrapartum nurses by increasing the responsibility and relying more on the electronic fetal monitoring than their own assessment skills and intuitive experience and knowledge (Hoerst & Fairman, 2000). As a result, nurses are spending less time providing emotional support and more time managing technology (Birkhead et al., 2012). Furthermore, kinesthetic skills such as palpation of intensity of uterine contractions and intermittent auscultation of fetal heart rates have been replaced with machine-generated data

of uterine activity such as amplitude of contractions, fetal activity and fetal heart rate tracings (Hoerst & Fairman, 2000).

Chapter Three: Methodology

Interpretive Description

This was a qualitative research study using interpretive description as a methodology. The study explored of the experience of intrapartum nurses in providing labour support. Developed by Sally Thorne, interpretive description's philosophical principles stem from naturalistic and constructivist beliefs and accordingly recognize that human experience is socially constructed with subjectivity that is experientially based while acknowledging the possibilities that multiple realities may exist (Thorne, Reimer Kirkham and MacDonald-Emes, 1997). Interpretive design is a non-categorical approach to address shared themes and patterns that develop from health related experiences together with the intention of creating new nursing knowledge (Thorne et al. 1997; Hunt, 2009). A methodology specific to applied health disciplines, interpretive description signifies a blending of hermeneutic practices with qualitative empirical methods (Thorne, 2008; St. George, 2010).

Through the application of an inductive reasoning approach, interpretive description suggests that nursing knowledge looks for characteristics, associations and patterns within the phenomenon that has been described (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004; Thorne, 2008). Interpretive description requires a thoughtful understanding that arises from two resources: a clinical practice learning objective and an understanding of knowledge or lack there of that are grounded on available empirical evidence (Thorne, 2008). Interpretive description offers a "logical, systematic, and defensible research strategy to address practice issues in a way that makes sense to the discipline, and could reasonably be expected to advance disciplinary knowledge and inform practice change" (Oliver, 2012, p.410).

Theoretical Framework

Symbolic Interactionism and Pragmatism

George Robert Mead is the originator of the term symbolic interactionism, followed by, Hebert Blumer, a student of Mead's who further advanced the theory of symbolic interactionism (Oliver, 2012). Blumer's perspective on symbolic interactionism was greatly influenced by John Dewey, a noteworthy pragmatist (Huber, 1973). Symbolic interactionism provides a theoretical perspective on how individuals act towards and interpret objects based on the meanings that these objects have for them. The individual and the context in which the individual exists are inseparable. Facts are therefore tentative and never absolute because meaning changes depending on the context for the individual (Benzies & Allen, 2001).

The core concepts of symbolic interactionism are meaning, language and thought (Carlson, 2012). Meaning is acquired through an interpretive process though the use of language to convey meaning. To understand and construct meaning, individuals need to think and reflect on previously learned experiences (Carlson, 2012). Traditionally childbirth has been an event in which women and midwives trusted a woman's body and viewed it capable of childbirth. As the profession of obstetrics has evolved, childbirth has been redefined to managing, monitoring, and control. Understanding the evolution of labour support, which reveals many changes over time in attendants, setting and interventions, is essential to understanding how nurses perceive and make meaning of their experiences.

A research question using a symbolic interactionism framework utilizes process as opposed to structure (Benzies & Allen, 2001). Research is focused on understanding the individual's point of view and the process by which this occurs (Benzies & Allen, 2001). Processes are meaningful because symbolic interactionism analyzes human behavior as a

dynamic behavior whereby individuals are continually defining and interpreting each other's actions (Benzies & Allen, 2001). Blumer (1969) affirms a researcher cannot observe individuals or objects or the interaction between them without acquiring an insight into how those interactions reflect on the individuals as people (Handberg, Thorne, Midtgaard, Nielsen & Lomborg, 2015).

The significance of placing meaning has been acknowledged as an important concept in symbolic interaction. The nature of the symbolic interactionism framework is derived from three premises: The first premise is that "human beings act towards things on the basis of the meanings that the things have for them." (Blumer, 1969, p. 2). Thus, people do not respond directly to things but attach meaning to things and act on the basis of the meaning. Following this assumption is the premise that the world exists separate and apart from the individual, however, the world is interpreted through the use of symbols or language in the process of the interaction (Benzies & Allen, 2001). Accordingly, individuals then act on the basis of meaning that is derived from symbolic interaction (Benzies & Allen, 2001).

The second premise is that "the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows." (Blumer, 1969, p.2). That is, meaning for an individual develops out of the ways in which other individuals act to describe things (Benzie & Allen, 2001). Within symbolic interactionism, it is presumed that the individuals are able to act due to a shared agreement of the meaning attached within the environment (Benzies & Allen, 2001).

The third premise is that "meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters." (Blumer, 1969, p.2). Accordingly, individuals interpret and guide their own behavior and actions based on how they

imagine others will respond through societal and cultural norms (Benzie & Allen, 2001). Individuals have the cognitive ability for abstract and reflective thinking that facilitates the formation of symbolic use of language and actions for the formation and communication of meanings that involves a common response in interaction with others (Benzies & Allen, 2001).

Using interpretive description as a methodology and symbolic interactionism as a theoretical framework provided an understanding as to the experience of intrapartum nurses providing labour support within a birthing unit. The methodological perspectives classified the experiences of the intrapartum nurses and how they placed meaning on providing labour support as influenced by nurses' relationships with woman in their care and the social environment in which they work. Symbolic interactionism and interpretive description share ontological and epistemological assumptions and therefore make symbolic interactionism an excellent theoretical framework (Oliver, 2012). The epistemology of symbolic interactionism stems from American pragmatism (Blumer, 1969). Pragmatism is concerned with action and change and the interplay between knowledge and action (Goldkuhl, 2012). The core of pragmatist ontology is actions and change and as a result, humans are acting in a world that is in a constant state of becoming. Goldkuhl (2012) states without action, the social structure is worthless. Action is key in pragmatism and is the way to change reality through purpose and knowledge. An influence of pragmatism is the practicality of the meaning of a concept or idea and the actions in response to the concept or idea (Goldkuhl, 2012). Pragmatism like symbolic interactionism and interpretive design share a mutual approach with human interactions in their natural setting with change and the relationship between knowledge and action (Huber, 1973; Goldkuhl, 2012). Both interpretive description and symbolic interactionism share a common focus on how individuals and groups interact in complex social action and create meanings (Oliver, 2012).

Method

Sampling

The study used purposive sampling techniques to recruit intrapartum nurses (full-time, part-time, temporary and casual) who provide intrapartum support to labour and delivery patients. Purposive sampling was used to recruit participants who served as "key informants" with experience to in the area of intrapartum nursing. Through their intrapartum nursing knowledge, they were able to share what is happening and why it is happening (Thorne, 2008). An exclusion criterion for the study was: registered practical nurses (RPNs).

Interpretive description does not set a recommended sample size and identifies it can be conducted on all sample sizes. However, Thorne (2008) acknowledges most sample sizes are small, generally between five and 30 participants. An appropriate sample size should correspond with and satisfy the research question (Thorne, 2008). The sample size should be reflective of the knowledge being generated and be representative of knowledge currently relevant to the specific discipline (Thorne, 2008). To seek multiple and various experiences and meanings of intrapartum nurses, the projected sample size was eight to ten participants. However, the resultant sample size was eight participants.

Setting

The location of this study is a hospital located in Northeastern Ontario. The birthing unit has eight LBRP (labour, birth, recovery and postpartum) rooms where patients will labour, birth, recover and have their postpartum stay in the same room. Of the eight rooms, there are two rooms that have bathtubs with showers and five only have showers. There are stools available in the shower for the patient to sit. Available to use on the birthing unit is birthing balls, rocking

chairs, and squat bars. Patients are also welcome to bring in anything that they would like to utilize during their birthing experience.

There are 25 staff registered nurses who are trained to provide triage assessments, antepartum, intrapartum, postpartum, newborn, post-operative care and scrub caesarean births. There are four nurses staffed during a 12-hour day shift and three nurses staffed for a 12-hour night shift Sunday to Thursday, and four nurses staffed Friday and Saturday. The nurse unit leader chooses the work assignment and nurses are assigned as either postpartum, triage, or labour nurse.

There are five obstetricians and five midwives. Obstetricians are not routinely in house and need to be called to come and assess patients and for deliveries. Anesthesia is available to patients upon request. Throughout the week, during the daytime, an anesthesiologist is on call and is in the hospital. Once the operating room completes the cases for the day, the anesthesiologist may leave for home and will need to be called to come to the hospital upon request for an epidural.

Electronic fetal monitors are located in each LBRP (labour, birth, recovery, and postpartum) and nurses must be present in the room to observe and interpret the fetal heart rate tracing. The electronic fetal monitors have the capability to support wireless telemetery in order to support ambulation and are also waterproof to permit a labouring woman to shower. The monitors cannot be submersed under water and therefore cannot be used when a patient is sitting in the bathtub.

Data Collection Methods

Interpretive description requires that a researcher bring their tenets and experiences to the interpretive process (Hunt, 2009). The researcher's knowledge and experience of intrapartum

nursing is a platform for which the notion of this study was built upon. Thorne (2008) considers interpretive description as a methodology in which the researcher has clinical expertise within the context of the study. Interpretive description requires the researcher to have sufficient grounding in the discipline together with an understanding of what is known and not known on the basis of all sources (Thorne, 2008).

Data was collected during the months of February 2017 to April 2017. The researcher is employed as a staff nurse in the birthing unit. If participants were uncomfortable with the dual role held by the researcher and as colleague to nursing staff, they were directed to contact Dr. Roberta Heale, thesis advisor who would arrange for a third party to conduct the interview. No participants took this option.

Potential for conflict of interest of the dual role was disclosed to the study participants in the research study information letter (see Appendix A) and consent form (see Appendix B). The research study information letter contained information about the study, risks and benefits. A recruitment poster (see Appendix C) and research study information letter was distributed to the clinical nurse educators at the hospitals and requested to post in the staff lounge and email to staff. Interested participants were asked to contact the researcher through the Laurentian University email to arrange an interview. Prior to beginning the interview, participants were given the research study information letter to read and ask any further questions. Participants were assured that their participation in the study was confidential. A pseudonym was assigned to each participant in the research study to protect the confidentiality of the data that was shared. Participants were advised they had the right to withdrawal from the research study at any time. If participants felt uncomfortable, or distress during the interview, it would be stopped and the

participant would be provided with the hospital employee assistance program resources and community counseling services contact information if needed.

Semi-Structured Interviews

In this study, semi-structured interviews were used to explore the experiences of intrapartum nurses while providing labour support. The researcher while conducting semi-structured interviews utilized an interview guide that contained five questions (see Appendix D). The interview guide provided a structure for which to conduct the interview, however the researcher also followed topical trajectories in the conversation that strayed from the guide when felt appropriate.

Each participant engaged in one, audio-recorded interview lasting between 20 to 40 minutes. Participants chose the place and time of the interview. Prior to initiating the interview, the researcher engaged in some social conversation to help place participants at ease. Most of the participants identified as being nervous and hesitant about what questions they would be asked and were concerned about providing the correct response. To alleviate some of the anxiety over questions, the researcher requested that the clinical nurse educator send a second email to nursing staff with a copy of the interview guide. Establishing and developing rapport with study participants is a vital element during interviews. It is through the connection of the researcher and participant that provides richness of the data (DiCicco-Bloom & Crabtree, 2006). As a result, the researcher must strive to create an environment that is safe and comfortable to enable the study participant to share their personal stories and feelings. Stages that participants and researchers will encounter to establish rapport during the interview may include apprehension, exploration, cooperation and participation (DiCicco-Bloom & Crabtree, 2006). The opening question should be broad and non-threatening to begin to engage the participant. The

participants were given time to listen and process the question before responding. The exploration stage is when the participant was involved and connected by sharing, attending and demonstrating engagement. All participants willingly took part in the interview and shared their experiences of providing labour support. A level of comfort and ease between the researcher and participants reflects the cooperative stage. At no time during the interview did any of the participants express feeling uncomfortable or a level of distress. The participation stage involves the participant informing and guiding their meaning of knowledge.

Unstructured Reflexive Journaling

Unstructured journaling was used throughout the research study. Journaling consisted of writing notes field notes during the interview on the interview guide and the researcher would circle potential codes evolving from the dialogue during the interview. A notebook was used after the interview to transfer thoughts and ideas that would be useful during data analysis.

Data Analysis

Within 24 hours of each interview, the researcher transcribed the interviews independently. Transcription of the data was done verbatim in order to capture the personal essence and rich description of the dialogue. Field notes were made during the interview on the interview guide and the researcher would circle potential codes evolving from the dialogue during the interview in a reflexive journal. Thorne et al. (1997) emphasizes analytic techniques that include promoting repetitive immersion in the data prior to beginning coding, classifying or creating linkages. This ensures synthesizing, theorizing, and re-contextualizing data as opposed to merely sorting and coding (Thorne et al., 1997). After transcription of an interview, a list was made with emerging codes, main ideas and topics using a reflexive journal. Within a few days after each interview, transcripts were re-read and audio recordings were re-listened to by the

researcher to ensure accurateness and ensure nothing was missed during initial transcription. Data were compared for similar codes, main ideas and topics among each transcript. After all the interviews were completed, transcripts were printed and were highlighted with different colours for emerging themes and categories and were compared with each transcript. Thorne et al., (1997), suggest that the researcher engage in intellectual inquiry to capture the complete fruitfulness of the data with questions such as "what is happening here?" and "what am I learning about this?" The initial codes were then grouped thematically and utilized to present the data findings.

Rigor

In the process of data collection and analysis, Thorne (2008) recommends specific requirements that entail specific criteria for ensuring credibility in research when using interpretive description; epistemological integrity, representative credibility, analytic logic and interpretive authority.

Epistemological integrity. Epistemological integrity is the demonstration of "…a defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained" (Thorne, 2008, p.224). Simply put, it ensures trustworthiness of the knowledge generated from the literature and interpretation of knowledge. The research question for this study was as follows: What are the experiences of intrapartum nurses in Northeastern Ontario setting in providing labour? The research question supports the premise of interpretive description that researcher are seldom satisfied with description only and are continuously exploring meanings and explanations of clinical phenomena of interest for the purpose of capturing themes and patterns. This qualitative, interpretive description research study used inductive reasoning to

explore the experiences of intrapartum nurses and the meaning they place on providing labour support.

Representative credibility. Representative credibility demonstrates that the theoretical assertions of the study are consistent with the study sample (Thorne, 2008). The phenomenon of interest in this study is registered nurses who provide intrapartum labour support working in the birthing unit. Therefore, the study sample is representative of intrapartum nurses and their experience providing labour support.

Analytic logic. Analytic logic is reflective of an essential process to ensure the researcher has followed and identifies the reasoning and epistemological claims of the study (Thorne, 2008). Analytic logic is enhanced by an audit trail that permits an outside researcher to follow the data collection and analysis. Credibility was enriched through a reflective journal and an emphasis on transparency throughout the research study and data analysis. For this study, the reflective journal was utilized to workout codes, themes and patterns in the data that were inductively analyzed to ascribe meaning to intrapartum nurses providing labour support.

Interpretive authority. Interpretive authority ensures rigor and credibility to the research process and validity to the interpretations of the researcher without biases (Thorne, 2008). In order to enhance credibility, the transparency of the researcher's position as a staff nurse was openly revealed in recruitment letter and research study information letter. All of the participants seemed comfortable in engaging in an open and honest interview with the researcher. For this study, efforts were made to reduce researcher bias by using the reflective journal to note how data was analyzed into codes, themes and patterns. Transferability of data was enhanced through description of rich and authentic quotes. The researcher interviewed and transcribed the data herself and was able to capture the nuances, vividness and generous

description of the participants' experiences. Member checks were not used during this research study. Instead the researcher used member checking throughout the interview to seek clarification if there was something said that was unclear or misunderstood.

Lincoln and Guba suggest four criteria for establishing trustworthiness in research: credibility, transferability, dependability, and confirmability (Houghton, Casey, Shaw & Murphy, 2013). Also included were the importance of the individualities of the researcher, who are recommended to be sensitive, accommodative and receptive to changing situations, holistic, and ability to seek clarification and provide summarization (Morse, Barrett, Mayan, Olson & Spiers, 2002).

Transferability. Transferability relies on thick description from the researcher to demonstrate that the study findings can be generalized or transferred (Houghton et al., 2013). Shenton (2004) researchers must provide a rich and detailed description of data in order for readers to make their own interpretation. In this study, the researcher provided thick descriptions using direct quotes during data analysis for the purpose of enriching transferability.

Dependability. Dependability refers to the consistency of findings from an in-depth methodological description (Krefting, 1991). Lincoln and Guba suggest that rigor may be accomplished by outlining a step-by-step replication of the decisions made throughout the research study (Krefting, 1991; Houghton et al., 2013). The researcher was very descriptive in identifying the precise methods of data collection, analysis, and interpretation (Krefting, 1991). An audit trail provides the reader with a comprehensive trail of decisions made during data collection and analysis. In this study, the researcher maintained an audit trail through comprehensive notes related to the background of the data and the stimulus of the rationale for all methodological decisions. A reflexive journal was utilized by the researcher to capture the

transparency of the researcher's rationale for decisions made, feelings, thoughts, ideas, questions to self and any personal challenges experienced during research. The aforementioned contributed in the development of the codes and themes during data collection and analysis.

Confirmability. Confirmability refers to the neutrality and accurateness of the data (Houghton, et al., 2013). Confirmability lends itself to auditability to ensure that the research findings are a result of the participants and not the researcher's. The role of triangulation in this study further contributes to confirmability to reduce investigator bias (Shenton, 2004). The researcher has disclosed her dual role as researcher and staff nurse working on a birthing unit. Participants were given an option to be interviewed by the thesis advisor in the event they were uncomfortable being interviewed by the researcher. The researcher provided an in-depth methodological description to support integrity of research.

Ethical Considerations

Research Ethics Board approval was obtained before conducting the study from Laurentian University Research Ethics Board (REB) and Research Ethics Board ethical approval from the hospital. Ethical issues were carefully considered while planning and implementing the research study.

Prior to initiating the interview, the researcher provided a research study information letter to the participant. The letter outlined the purpose of the study, procedures and the benefits and risks of the study. Participants were assured that their participation in the study was confidential. They were advised they had the right to withdrawal from the research study at any time or refuse to answer any questions without judgment or penalty. The main risk to participants through participating in the research could be transient, such as a temporary emotional reaction to a response from a question. If participants felt uncomfortable, or distress

during the interview, it would be stopped and the participant would be provided with the hospital employee assistance program resources and community counseling services contact information if needed.

The researcher clearly defined and articulated her role to participants in the research study information letter and consent form. Jack (2008) implies that when using interpretive paradigm that a subjective approach be adopted by the researcher who participates in the interview by establishing rapport generated by openness and respect. The researcher is very much part of the research process as a staff nurse and created an environment for which meaningful information was shared by the participants. While it is impossible to reduce all inequities of power, the researcher must protect the participants' right to anonymity, confidentiality, and decrease any future psychological, physical or social risks associated with participating in the interview (Jack, 2008). The researcher has no way of projecting any future positions of power that the researcher or participants may hold and the impact for the future of participating in this study. Participants were aware of the researchers dual role and chose to willingly contact the researcher to arrange an interview and participate in the study. Furthermore, the research study was vetted through two separate research ethics boards.

Chapter Four: Findings

The purpose of this study was to explore the experiences of intrapartum nurses in a Northeastern Ontario, Canadian setting and the meaning they place on providing labour support. The results of this inquiry were based on semi-structured interviews with a purposive sample of eight intrapartum RNs currently practicing at a birthing unit located in a Northeastern Ontario hospital. The research question was: What are the experiences of intrapartum nurses in providing labour support in a Northeastern Ontario setting? To enhance the trustworthiness and credibility of the data, the research findings will be presented with the eight participants' experiences. Personal demographic data were not collected on the participants to preserve their anonymity. All participants were registered nurses trained in labour and delivery and met the inclusion criteria as outlined in the study. The following five themes emerged from the data: Enhancing the birthing experience of women through labour support, birthing technology and medical paradigm, birthing environment that influences the intrapartum nursing care, interprofessional collaborative relationships and intrapartum specialists.

Intrapartum Specialists

Throughout the interviews, participants identified that quality-nursing care for women in labour combines many intrapartum nursing skills. Nurses shared they don't always know what to say to patients or sometimes what to do when providing support. Learning how to provide labour support is not a course or a learning package that is offered. Thus, nurses rely on personal and professional experience and mentoring from their peers.

Nurses frequently considered themselves to be managing the labour when describing their experience. Nurses described their role as working autonomously within the birthing unit and while providing support also managing labour by performing vaginal exams, interpreting the

fetal heart rate and contraction patterns and adjusting the oxytocin accordingly. The obstetrician on call is not always in house however, is available via telephone. Accordingly, nurses described their experience as having to make decisions and problem solve in relation to patient care.

Rose identifies herself as a senior nurse and shares how she learned to provide labour support and expresses concern that nurses are not learning the art of providing labour support.

> Rose: I was mentored from my colleagues that were senior to me from when I started as a young nurse and learning best practices from them. Learning what worked and what didn't work. Learning how to be attentive. It was mentoring from basic assessments, what is a good contraction versus a poor contraction, how do you tell the difference, how do you explain that to the patient. Also, the patient is having back pain, how do you alleviate back pain, what does back pain mean? What do you suggest to the patient. You know you learned that on your orientation and on your mentorship but it was an ongoing thing, where you would be trying something and it wasn't working and a senior nurse, and I mean I was very fortunate, I was a junior nurse for 18 years so I learned for a very long time, you know, how, what did the older girls find that worked and how did I incorporate that into my practice.

When asked how mentoring has changed since Rose was a new nurse, she shared that the staffing complement is much different and includes a younger cohort of inexperienced nurses who are mentoring new staff. Accordingly, she points out that the younger nurses are well versed in providing medical and technical support and as opposed to labour support.

> Rose: I do think that younger and junior staff is being mentored in the same way but the problem is that you have people with two to three years experience mentoring brand new staff. Whereas when I was mentored and some of the other senior staff by older nurses we were being mentored by people who had been doing it (labour support) a long time. …I just think that the level of experience on our particular unit has changed dramatically and I think because of that and the use of epidurals, I don't think that we provide labour support that we did say ten years ago. Our unit has a lot of younger staff that have never had children themselves yet, and I do believe that when you've been through something yourself, it changes your perspective and has a big impact.

Another participant identified that she continues to learn as an intrapartum nurse on how to meet the needs of her patients. She shared that an important element for her is to have a physical presence in the room without necessarily saying anything to her patient.

> Megan: Or I think that one of the things that I found the hardest, learning my role, and I'm still learning, is how to just be there. Because it can be uncomfortable if you don't necessarily know your patient that well and they don't know you that well but I think that that's a huge part of labour support is that the patient, the woman knows that someone with the knowledge and expertise and background in this is right beside her or very close by.

Enhancing the Birthing Experience of Women through Labour Support.

Participants reflected on the many approaches to offering labour support. Participants acknowledged that it is important within their role, to learn about the patient to ensure a positive and memorable childbirth experience. Labour support was portrayed as being organized into categories of providing emotional support, physical support, advocacy and teaching or informing. Interestingly, almost all participants would distinguish between physical and emotional supportive measures. All participants in the study described a shared experience of what labour support meant to them using common words such as caring, teaching, listening, advocating, empowering, encouraging, and negotiating. Participants when describing physical supportive measures used more kinesthetic words such as touch, handholding, rubbing, wiping hair, guiding, and moving.

Nurses put forth an effort to understand how to meet the needs of women to enrich their labour experience. Participants shared their experience on conveying their philosophy of labour support.

> Rachel: Listening to my patient and getting a sense of what they want and need out of their labour experience and trying to provide that for them.

> Rose: To make the experience for them, be what is, or what they expect, or what they hope it to be and, provide them guidance too. When things don't go the way that they expect, to make sure that they know the normals, the abnormals, how to best cope with different stages of labour, what tools we have available, and continued one to one support to that woman and her family, to help her through the stages of labour.

> Tessa: I do my best to try and get a read from my patient from what it is that they need from me. My personality is one of a bubbly nature and I'm humorous and if I feel that the patient is going to appreciate that and that it's going to help them cope, then I'll be very much myself. Or, if I determine that the patient wants a more calm or quiet atmosphere, then I will make my presence known just by brushing her hand and maybe a little less verbal and more just being there for her in my presence.

Almost all participants expressed how teaching, informing and educating about the childbirth experience enrich the experience for women and their support people by empowering them with knowledge to make their own decisions.

> Penny: You are doing a lot of teaching, I find it is really important because you need to get your patient in the right mindset and that helps them a lot with coping emotionally. You know that they can do this. Not to give up, that they can do this.

Some participants described supporting women as simply having physical presence in the room and just being there with the patient. Being there with the patient does not necessarily mean that anything is required or expected from the nurse, but just their presence in the room provides a calming and reassuring environment.

> Rachel: just being there for the patient while they're in labour, being available and being knowledgeable about comfort measures and how to handle different situations and you listening to them.

> Megan: Sometimes we are just there in the room, not necessarily doing anything nursing related but being there as a support, just someone that they can trust and know, it's ok my nurse is with me, it's ok.

A few participants remarked that confidence through acquired knowledge and practice as an intrapartum nurse lends to the ability to be assertive with patients by guiding, as opposed to asking them.

> Jenna: As much as I can say it's (labour support) about positive reinforcement, encouraging, even though you're not sensing that they are receptive to your teaching and to your guidance, sometimes you have to be a little bit, I don't want to say forceful but maybe assertive. And make them try something that they may not want to try. For example the shower, or getting up and moving around, they have a lot of fear as they are in pain and pain tends to bring fear. I think it's just to, with having dealt with numerous women in labour, we have an idea on what will help them, what could help them and it's

> our job to guide them and help them to go through the process. A lot of teaching and they look to us for guidance and that's part of our job and role is to guide them and teach them and help them.

Childbirth was identified as being a significant event in a family's life. Almost all accounts of describing the experience of providing labour support were inclusive of the labouring woman, support people and family. Participants remarked that it is integral that care be family-centered when providing emotional supportive measures and teaching. They emphasized the importance of facilitating family involvement and communication during labour.

> Brooke: Families can become nervous, scared or upset when they see someone that they love in labour and they aren't certain about what's going on. They're trying to do the best job and sometimes they need support and encouragement from us as well rather than just the patient themselves.

> Rachel: Helping to facilitate the entire family or the other support people and thinking that every patient is different with what they need and want and being able to adapt to that and helping the family members be involved in that as well.

> Tessa:…I'm trying to perceive if I walk in and there's three support people and they are chatting and laughing and then I would try and establish my rapport with them that way, explain who I am, what the plan of care is that has been determined, how well is the patient coping right now and kinda take that through, subject to change at any point.

A few participants remarked on their own birthing experiences and the role it has played in influencing their labour support.

> Megan: I actually learned a lot when I had kids. I think that's a huge benefit to me now that I've had kids and have had had the experience of being on the other side of care.

> Jenna:…it's a very positive experience in that they are bringing their baby into the world. So it's a memorable experience for them and having had kids of my own, I remember every detail. I just want to be there for them to have them to have a positive experience and that they have it in their minds that it was a good experience.

While participants ascribed importance to the involvement of family when providing labour support, they equally identified family dynamics as hindering labour support. Participants shared they make every effort to provide family-centered care, however at times, respecting the

patient's wishes while balancing beliefs, expectations, and comments made by family members was sometimes taxing.

> Rose: … empowering the woman to know that if mother in law wants to be in the room and that's not what's comfortable, that it's ok, and that's what I'm there for, I can be a gate keeper for her. That it needs to be what's comfortable for her, and it's going to be what's going to help her progress the fastest and the best. I'm comfortable not making everyone happy but the most important person in the labour and delivery room is the mother and the father and doing what works for their dynamics.

Overwhelmingly participants described the personal and professional satisfaction received from being able to take part in the childbirth experience. It was very evident in all of the participants, the passion and genuine affection of providing labour support to women. Most participants concluded their interview with an assertion of loving their job, and the feeling of personal satisfaction attained.

> Tessa:…your patient is having a life changing period of time. How you are with that person they are going to positively or negatively remember you and that labour experience forever because they positively or negatively had a baby. It's a privilege to have this job and provide the support to them. I love my job.

> Brooke:…I love it. It's (labour support) my favourite part of my job. I think everyone when they come on (shift) and they are labour, most of the time are happy. It's really an exciting place to work and you go home and you feel great about the job that you did.

Another participant enthusiastically concluded the interview with:

Jenna: It's absolutely the best job in the world.

Birthing Technology and Medical Paradigm

The majority of the participants discussed the challenges of caring for women in today's culture of technology and medical lead intrapartum care. Participants identified differences in caring for women in labour who have epidural anesthesia and or receive medication such as oxytocin and require electronic fetal monitoring. Participants shared that their experience while providing labour support was very complex and encompasses many task-oriented functions of

nursing often superseding the emotional support and physical comfort measures.

> Penny: With the use of medical interventions, you're in the room more frequently. However, I find because there's so many things going on, like drips to look at, epidurals to be checking, that you're in the room with your patients and you're always assessing but I find sometimes that it takes away from that one on one emotional support.
>
> Jenna: So you just have to remember as much as there is the medical side, so yes you're documenting, you're increasing your oxytocin but you can't forget the there is a patient. That patient regardless whether they have an epidural or not, they still need that positive encouragement and you know they need you, so it's not a matter of oh great, they're getting an epidural so I have don't have to do anything anymore. That's not true at all, because they look to you for guidance and they look to you to know that things are happening normally and things are progressing the way they should be and that's part of your job is to just help them through regardless of what is going on medically and what interventions are happening.
>
> Tessa: I find that it (electronic fetal monitoring) can be quite distracting from providing labour support. You're in the room and it might appear that you are providing labour support when really half the time you're managing equipment. You are having to go and retrieve another nurse to come in and sign for your epidural, sign for your oxytocin, coming in and out because you need blood pressures taken and dealing with cords and equipment, not standing at the bedside or helping to coach by instructing patients to breathe or providing good labour support. You're just managing, trouble shooting your equipment.

Most participants commented on the use of continuous electronic fetal monitoring and how it impedes the birthing experiences of women and as a result changes their approach to labour support. All participants agreed that the use of technology such as electronic fetal monitoring and medications such as epidural analgesia and oxytocin are being used more frequently to accelerate the labour and delivery process. All participants emphatically agreed that with these interventions, they are being drawn away from supportive care of women in labour and have become preoccupied with the management of technology. Almost all participants describe care happening at the bed or bedside while providing support. Participants do not discuss the use of wireless, telemetry monitors to enable patient to ambulate while on continuous electronic fetal monitoring.

> Penny: When you are focusing on an electronic fetal monitoring strip, for example, sometimes that's all you're looking at instead of looking at your patient or you really have to remember to be feeling those contractions and timing those contractions and talking about patient perception instead of looking at the contractions on the strip. Sometimes I find that we end up being more focused on what's happening on the monitor than what's happening otherwise.
>
> Tessa: We're managing the machines and not supporting the person. It's mechanical care.
>
> Rose: I think sometimes that nurses become as soon as you enter into that entire medical portion of obstetrics, that our focus as nurses becomes that medical management component and perhaps we don't provide as optimal labour support that we would have without all those components that become our focus. You know when you have someone that you're doing an intermittent auscultation on, you're in the room, and you are interacting with the patient. When they're on continuous electronic fetal monitoring, you walk in, you look at the strip, you know, you become obsessed with that and forget about the patient that it might be attached to.

One participant spoke about the changes in intrapartum support that have evolved over the years. She expressed her concern as a senior nurse that the knowledge of the new generation of nurses is entirely based on technology and medical intervention practices. She fears that the knowledge and skills required to support vaginal deliveries would be lost.

> Rose: I find that with the increased use of epidurals at our unit, that labour support has become less important because the patient isn't experiencing pain the way that they were. And I think that my experience as an older nurse before our routine use of epidurals, we learned very good labour support because your patients didn't cope without you being there and coaching them through. But I think that our increased use of epidurals has decreased our proficiency.

Challenging the overarching theme of birthing technology and the medical paradigm impeding labour support, two senior nurses shared their experience. Both participants described their strengths of being able to simultaneously manage medical and technical interventions while providing labour support.

> Rachel: I've been doing it (providing labour support) for so long, that I just get used to working around and with it and multitasking instead of focusing on the technical part. You're able to focus on your patient providing that support while also managing the technical and medical staff.

> Rose:...I think that I can rely on my experience and I nurse with my ears a lot of time when I have a labour, so I don't feel that it does with myself (affect labour support). Because I also can rely on 30 years of experience of knowing when I can't multitask anymore but there are times that the workload is just too intense.

However, both participants when asked to reflect recollected their experience as once being novice nurses, and acknowledged the ability to be able to manage labour support and medical and technical interventions required multitasking, knowledge and wisdom.

> Rachel: I definitely remember as a new nurse starting out and feeling really overwhelmed with the fetal monitoring. With that you have all the other monitoring, say for instance if you have magnesium sulfate or something like that. I found it really hard starting out to be able to provide that support because you're really focused on getting it right with the technical and medical stuff. It takes a good couple of years to be able to as a labour nurse to be able to get to that point (being able to manage) because I remember feeling really overwhelmed at the start and especially with high-risk cases. Looking back now, I definitely didn't provide the kind of support that patients needed and the support that I like to provide.

Participants shared their vision of how they would provide labour support to a patient who they describe as being low risk and not requiring any interventions. They detailed the emotional support and physical comfort measures that they eagerly wish to provide.

> Tessa…a low risk patient that comes in and needs intermittent auscultation every half an hour who I realize is in pain and I give her something for pain and I recommend the birthing ball, I get her into the shower on the birthing ball. I stand with her and I hold the showerhead and help her to breathe with her contractions. I'm just providing physical, emotional and spiritual support the whole time. I am not managing or barely touching equipment, I'm just touching my patient.

> Brooke: I would like if my labour support could be you know just focusing on the woman but it can't always be. You need to split your time. I would like it if we could do still getting in the shower and hot blankets and walking up and down the hall but it's not always possible when they're on electronic fetal monitoring, you can't make it work all the time and our population is getting larger and it' hard to monitor all the time. So ideally I'd like it if I could just walk in the room and give support to my patient but it's not always ideal.

Another participant shared her vision of providing labour support for low risk patients, however, identified an awareness of patient safety and legal concerns using electronic fetal

monitoring. She echoed the challenges shared by other participants when using interventions and the restrictions placed on patients.

> Brooke: When you walk in the room, sometimes the first thing that you are going to look at is your strip, when really who you should be looking at is your patient. And it's hard because that's what you are documenting on is your strip. That's what can come back in legal cases and that kinda stuff so it's often times your main focus. Which is sad but then every once in a while you get a labour that has no interventions and it's refreshing because you can just focus on your patient. I find it difficult with a lot of interventions. I think a lot of us do really. Sometimes you're sad that you have to start one, when you don't think you need to because it's going to take up your time from your patient. And the patient doesn't enjoy them all the time either so you have to do a lot of supportive teaching. You know them having electronic fetal monitoring on. So many times you have to repeat why they have to have these belts on and it's uncomfortable for them.

Birthing Environment that Influences the Care that Intrapartum Nurses Provide

Professional pride was a common theme identified by nurses, who embrace a high standard of care when providing labour support. When asked about the Society of Obstetricians and Gynecologists (2012) collaborative recommended guideline entitled "*Joint Policy on Normal Childbirth"* and specifically with respect to providing one-to-one labour support, participants were passionate and expressive in describing many factors that impede the implementation of this guideline. Factors included, staffing patterns, staffing complement, and LBRP (labour, birth, recovery, postpartum) model of care as barriers. Participants also voiced frustration with staffing patterns and unit activity hindering their ability to establish rapport with labouring women.

Participants portrayed their experience with the LBRP (labour, birth, recovery, postpartum) model as having to simultaneously provide care for multiple patients at once, potentially being antepartum, intrapartum, postpartum, scrubbing for a caesarean section, or assessing patients in triage. Participants frequently described feeling overwhelmed and at times having a sense of despair from being pulled in multiple directions, and not being able to provide optimal care.

> Penny: We've had times that there's been so many labours on the floor, that sometimes, we are tag teaming a little, because of being short staffed and I do find the ones (labours) that are less complicated, tend to be the ones who are less one to one (labour support).
>
> Rachel: Because we are a small unit and our model of care, the LBRP (labour, birth, recovery, postpartum) concept and having to juggle so many things, sometimes at once, is a challenge because you have to worry about what your postpartum patients are doing, you have to worry about what else is happening. It's not just a labour and birth focused unit and mindset, so it sometimes, can be challenging.
>
> Rose:…often, when you are assigned a labour patient, you are also answering call bells, helping with breastfeeding, assessing a patient in triage, doing multiple tasks at the same time.

Participants confessed that sadly some patients may not receive the quality of labour support they pride themselves as providing. Participants identified as feeling badly, guilty, torn, and worry for not being there for the patient. They described a common experience of having to take away time from one patient to reallocate to other patients. There is a divide among participants who believe that during busy times it is easier to take time away from the labouring woman than it is with antepartum, postpartum and triage patients. While other participants thought that the other patients on the floor suffer while the labouring woman receives the care. Participants all agreed that it depends on the unit activity on who receives the most care. Nevertheless, participants felt that regardless patient care can be jeopardized with a busy floor and not enough staff.

> Brooke: Probably the thing that's going to fall through the cracks is your labour support in that case. Because so many things here are time-senstive and labour support isn't time sensitive. You can walk in the room and 15 mins later you can give the same support so you put it off and then you put it off again. It's unfortunate for those patients for sure that I only have time to walk in for my 5 minute check and then go see someone else.
>
> Rachel: Staffing, again, can be a concern, when we're busy and we have multiple labours or multiple things going on, and we don't have extra staff to come in, sometimes that is really challenging. Because you're trying to manage and balance the labour support that is required with what else is happening on the unit, right, because we are a small unit and um I think that our model of care really, the LBRP (labour, birth, recovery, postpartum) concept and having to juggle so many things, sometimes at once, is a challenge because

> you have to worry about what your postpartum patients are doing, you have to worry about what else is happening, it's not just a labour and birth focused unit and mindset, so it sometimes, can be challenging.

Participants perceived building trust and rapport to be salient and influential when providing labour support. However, participants express frequently feeling constrained with providing labour support as a result of staffing issues, either being short staffed, or not enough staff to accommodate a busy unit. Interwoven in the interviews was a feeling of concern and compassion when discussing how patient care is affected during busy times. Participants empathized greatly with patients when they cannot provide optimal care. There is mention of the LBRP (labour, birth, recovery, postpartum) model that the participants feel contributes to a lack of privacy and accordingly most patients on the floor are aware of unit activity. As a result, participants found themselves having to explain to their patients why they are not able to provide the care required.

> Tessa: Well you are trying to multitask more, trust and communication with your patient and support people during a life-changing event. Being interrupted or pulled away or having that assignment changed and a new labour nurse assigned mid-way would be incredibly disruptive to the patient and a breach of trust to that patient I feel.

> Tessa: I find a lot of patients in LBRPs (labour, birth, recovery, postpartum) are quite aware of what else is going on the unit. And can feel that pull. As well as with being honest and communicating with your patient, you have to explain to your patient why your care is being interrupted all the time "sorry about that, we just have another delivery happening down the hall as you might have heard" or "sorry about that we're just going for an emergency caesarean section right now or we have an emergency down the hall or whatever it is." Yeah they certainly are perceptive and if not, you are making them aware of why you are absent.

> Brooke: Sometimes you actually have to tell the patient, you know I have other patients as well and I'm going to try and do my best. But I do have other people to see. I find it affects my postpartum patients too because you try to give your labour all of your attention knowing how important that is so your other patients may get left behind more than your labour patient. But it definitely affects your rapport because you just don't have as much time with them as you could because you have other things on your mind, you're in there doing a labour check and thinking about how you have to go and do a blood sugar on another baby. It's complex.

Another participant expressed concern with staffing complement and feeling supported by the senior staff (defined as most senior in experience).

> Penny: I would say for our unit in particular it could be that staff complement (affects labour support). And that in regard to just how many staff we have on that day shift normally or even just experience of staff. Say, we have 3 junior staff and 1 senior staff, with 2 labours. The senior staff is somewhere helping someone else, then you feel not necessarily the most supported because availability of resources.

Participants talked a lot about the non-patient care tasks that are required from nurses. Staffing issues, charts, answering the phone and other administrative tasks were discussed. Participants stated that depending on the time of the day or on nights, we don't have the support of ward clerks who assist with putting together charts, answering of phones, and other administrative tasks. Participants also talked about the time-consuming and frustration of having to find staffing if the floor is busy and the staffing office is not available. A participant points out that these tasks take away from providing labour support.

> Penny: …you could have a patient who is low risk, and somebody else has another (labour) patient, you might go and put their chart together and you might be spending less time in the room with your patient because your patient doesn't necessarily need any medical interventions at the time. So you're helping somewhere else where you might be more needed in that moment. Whereas your labour patient could still be using that emotional support.

Interprofessional Collaborative Relationships

Participants described a collegial respectful relationship with physicians, nurses and management and how much they value working as part of an interprofessional team. Professional responsibilities in their role as an intrapartum nurse include providing for and managing the intrapartum phase. Participants discussed the decision-making and competing responsibilities of providing labour support and maintaining the high quality standard care of

nursing. Participants shared what makes a positive work environment and the impact of a good labour nurse on birth outcomes.

> Tessa: Providing good labour support requires support from my institution and my co-workers and the OBs, the facility wide. So I can provide good support when I have got people encouraging us to be in the room and be at the patient's bedside.

> Penny: When you have the ability to provide one to one labour support, when you are not stressed with your communication with certain doctors, or when you have staff working with you that you feel supported, and you could ask questions to. When you feel more confident about your case, you could instill more confidence in your patient. Support makes me feel confident in my labour case from staff, resources and physicians.

> Rachel: I think the support from colleagues and the model of care that we use on our unit and just the way that we have all become accustomed to what is required for our unit and in particular for labour patients. We know that it's one to one (labour support), so we definitely work together to make that happen for our patients. We're very passionate about the care that we provide, I feel. We really care about our patients and the experience that we're providing for them. And I also feel that we have support from our management in maintaining that level of care, and you know, there's never any question if we say that we need more staff, we've never been denied in calling in for extra staff, but you know, getting staff is another problem.

Although participants discussed a collegial environment to facilitate the provision of labour support, participants also mentioned unit culture as a reason for hindering labour support. Some participants expressed their disappointment about a culture that is created by fellow nurses and the impact on provision of labour support

> Katie: There can be, you hear people saying why is she still in the room, what's taking so long if you are going in for a check. You hear people saying why is she still in the room, you hear people saying that she is taking too long to do her checks, what are they doing? You know there's all this other stuff going on (on the unit).

Participants shared of their uneasiness when observing peers doing what they describe as 'checks' on their labour patient. They expressed concern about nurses who go into their patient's room and check on them by checking the electronic fetal monitoring, or checking the epidural or oxytocin and then returning to the nursing desk. The inference of this concern is that nurses are

not providing labour support but checking in on their patient and returning to socialize at the nursing desk.

> Rose: Spending a lot of time with the patient and family in the room, not providing labour support from the desk.
>
> Megan: I think the nursing culture of any unit will affect the care that's given to patients. Sometimes I find that on our unit, there's sometimes a focus, not a focus but definitely camaraderie amongst our staff. I find sometimes it's labour checks, sometimes we go in and do our check and come back out to the desk. …Sometimes patients don't want you in the room the whole time, they may not be comfortable with that but I also think it can impact their perception of the support they're getting and also the support that they are or not getting.

Some participants voiced frustration with physician timelines and unnecessarily using oxytocin to expedite the labour and delivery process.

Katie: Sometimes physician's agendas can be barriers. If they have plans for inducing somebody or having them delivered by certain times. I think that can be a barrier because if the patient didn't have oxytocin, then you would just be treating them like a low risk pregnancy and you would have more time to give that physical and emotional support.

Chapter Five: Discussion

The purpose of this qualitative, interpretive description study was to explore the experiences of intrapartum nurses in a Northeastern Ontario, Canadian setting and the meaning they place on providing labour support. This is one of the first research study's exploring the Northeastern Ontario intrapartum nurse while providing labour support. In this chapter, the five themes that emerged from the data: Enhancing the birthing experience of women through labour support, birthing technology and medical paradigm, birthing environment that influences the care that intrapartum nurses provide, interprofessional collaborative relationships, and intrapartum specialists will be summarized separately with supporting relevant literature. The themes although discussed separately are in fact interwoven and form a tightly knit tapestry representing the experiences of intrapartum labour support. This chapter also integrates the implications for nursing practice and nursing research and discusses the limitations of the study and conclusions.

Enhancing the Birthing Experience of Women through Labour Support

Labour support embodies the heart of caring and nurses have a unique opportunity to enhance the birthing experience for women. Labour support is a wide-ranging term for providing the caring support that is offered to women during labour and birth (Davies & Hodnett, 2002; Sauls, 2006). Participants spoke about their provision of labour support with rich detail and emotion. Participants shared commonalities on how they described labour support and discussed the quality of care they provide and how they integrate an array of skills and behaviors to ensure a positive and memorable birthing experience for women.

The introduction of obstetrical interventions has provided labouring women with a sense of security and a perception of reduced harm to their newborn and themselves, as well as choices to lessen or avoid pain in labour (Zwelling, 2008; Sherrod, 2017). However, the use of

obstetrical interventions has the potential of removing women from the center of their birthing experience. The influence of feminism has offered women more autonomy and power by having a say in their birth (Brubaker & Dillaway, 2009). Feminism perspective brings it back to woman-centered care. The focus is on the woman. Women are encouraged to advocate for themselves in the hospital environment through a birthing plan and nurses will endeavor to provide supportive care to advocate and carry out the wishes of the labouring women. Caring is a fundamental paradigm within nursing (Duffy & Hoskins, 2003). The underpinning of caring in intrapartum nursing is relationship-centered patient care. Labour support is described as being an important component of intrapartum care, and nurses are expected to know what labour support is and what to do. Time spent initiating, fostering, and sustaining a caring relationship is often an unnoticed and undervalued aspect of nursing (Duffy & Hoskins, 2003). Participants describe trying to get a read from the patient on what it is that they want, need, or wish to have during their labour experience. Duffy and Hoskins (2003, p. 78-79) portray "human interaction as the primary focus of nursing that distinguishes it from other health disciplines." Participants discuss using their assessment skills to determine the needs of the patient and family. This information often comes in the form of a written or verbal birth plan, however, interestingly; participants did not discuss the use of birth plans. The purpose of a birth plan is to highlight the wishes, hopes and preferences of the expectant parents throughout the labour and delivery experience (Hidalgo-Lopezosa, Rodríguez-Borrego, Muñoz-Villanueva & Carmen, 2013). The birth plan is a document that is presented to the obstetrician and intrapartum nurses that outlines a plan for positions during labour, analgesia and maternal and newborn interventions. The plan provides a sense of empowerment and control to the labouring woman that contributes to supportive birth environment. Participants used common words to describe their experience with patients and

families as offering advice, guidance, information, emotional support and physical comfort measures. Participants emphasize many times about the value of effective therapeutic communication that promotes a caring, empathetic, and respectful relationship between the nurse, labouring woman, and her family.

Labour support when described by participants often included family-centered care. When participants described the act of providing labour support, they often included the family in their interventions. Some participants talked about when first meeting the labouring woman and her family, they attempt to individualize care to meet their unique needs. Participants recognized the many emotions that families may encounter; fear, scared, nervousness and anxiousness while watching the loved one experience the labour process. Therefore, participants discussed fostering a culture of openness by encouraging and promoting communication, teaching, and providing emotional support. Some participants discussed the importance of having support people involved in the comfort measures. Simkin and Bolding (2004) tell the importance of role modeling to support persons, with appropriate emotional support and providing guidance on active participation to contribute to relieving pain and enhancing labour progress.

Management of pain in labour is one of the main goals in the provision of labour support (Simkin & Bolding, 2004). Some participants describe comfort measures as sometimes being short lived due to a high epidural rate. As a result participants shared what they currently implement and offered a vision of non-pharmacologic comfort measures. Participants used words such as guidance, encouragement and teaching as techniques they would utilize to empower the labouring woman to cope with the pain of the contractions. Participants suggested using physical comfort measures to encourage the labouring woman to remain active by using a

birthing ball, shower, or simply ambulating. Participants described utilizing these labour techniques as a method of encouraging the patient to imagine and visualize the pain of labour into an experience of demonstrating strength and self-confidence, which consequently they feel leads to a positive birthing experience.

Some participants ascribed meaning to simply having a physical presence in the labouring woman's room. Participants talked about the significance as being present in the room and being with the labouring woman and not necessarily to performing any nursing tasks. Participants describe rarely being able to just spend time in the patient's room without having to perform checks on oxytocin, epidurals and electronic fetal monitoring. Jackson (2004) defines nursing presence as being with the patient in an all-embracing physical, emotional, psychological and spiritual encounter. MacKinnon et al (2003) describes nursing presence as "the essence of the professional nurse's caring relationship" (p. 30). This presence contributes to an emotional presence and trusting relationship that provides reassurance to the woman that the nurse is there to offer support (MacKinnon et al., 2005). Although some participants outlined the significance of presence, others explain that there can be awkwardness with offering presence in the patient's room. Some participants described it can be from not knowing what to do or say and others report if there are support people present, they felt at the time that they are not required to be present in the room. Experience and knowledge are factors that may contribute to the intrapartum nurse's level of comfort by being present in the labouring woman's room. Physical presence and total attention to a laboring woman's needs coveys that she is valued and respected (Albers, 2007).

Nurses exhibited a great deal of pride and honor in the care provided. Relationships characterized by caring are theorized to influence positive outcomes for labouring women (Duffy

& Hoskins, 2003). All participants felt that providing labour support to women during childbirth was a rewarding experience and taking part in one of the most significant events for a woman and her family is both a privilege and honor. Simkin (2002) in a longitudinal study, reveals that women long after giving birth, recall their birthing experience and the nurses involved in their care. Participants intensely talked about their positive experiences and shared the honor of developing therapeutic relationships with patients that brought them great joy and meaning. All participants exemplified passion and a commitment to intrapartum nursing and to supporting a positive birthing experience for the labouring women.

Birthing Technology and Medical Paradigm

Birthing in Canada is a medical and technical event (van Teijlingen, 2005; Zwelling, 2008). The medical model and the rising use of technology and unnecessary intervention are jeopardizing the normalcy of physiologic birth (Zwelling, 2008; Heelan, 2013). The provision of intrapartum support has resulted in professional changes that have been greatly influenced by the medical paradigm and the use of birthing technology. As a result, the intrapartum nursing role demonstrates a dichotomy between performing in an increasingly technological and medical model and providing the humanistic bedside skills required for a labouring woman (Fleming, Smart & Eide, 2011). Although faced with these challenges, participants discussed the personal satisfaction of endeavoring to ensure a positive experience for women and their families. Korhonen, Nordman and Eriksson (2015) suggest that technology challenges the caring relationship between patients and nurses and thus has changed the role for nurses. Participants discussed the challenges they faced managing multiple tasks while trying to balance providing support for the labouring woman. Crozier, Sinclair, Kernohan and Porter (2006) highlight that care can be the focus when the care is patient focused and not machine focused. Some

participants describe watching the machines such as the electronic fetal monitor as opposed to watching the patient. Sandelowski (1996) discusses a change in nurses relying more on machines than their own intuition and own senses and are "watching" as opposed to "watching over" patients (p.11).

At the forefront of the discussions, participants described the many challenges of integrating caring behaviours with technological skills. Participants within this study suggested the aspects of technology and the medical paradigm were particularly salient to their experience as nurses when providing intrapartum labour support. Crozier et al., (2006) report when there are high rates of medical interventions, nurses become sidetracked with focusing on technology, documentation, and monitoring the labouring woman in order to provide safe care rather than providing labour support.

A remarkable finding was how participants viewed labour support to have dual meanings. Participants when sharing their experience of providing labour support spoke separately about labour support by classifying it as being supportive care along with managing technical and medical care. Consequently, the two nursing tasks were divided into categories when discussing their experience and viewed as being separate by the participants. Additionally, participants further separated their experience by referring to labour support in a low-intervention, which usually meant low-risk labour and a high-intervention labour. Low-intervention births when described by participants discussed what methods of physical support they would implement such as the shower, birthing ball, and ambulation. Participants further described the emotional support they would provide, such as therapeutic touch, being present, and communicating to the patient that she's doing a great job. High-intervention meant managing machines, equipment, IV lines, double-checking medications, and doing checks on patients. High-intervention did not

always mean that a patient was high risk. However, participants inferred that high-intervention would require more monitoring of machines and performing regular checks with the machines. As a result, this prevented nurses from using the labour support interventions. Lying in bed during labour has developed in parallel with the use of medications such as epidural analgesia and the use of electronic fetal monitoring. There are physiological disadvantages for labouring women in a supine position (King & Pinger, 2014). The literature outlines many benefits to being in an upright position and ambulating (King & Pinger, 2014). Participants felt strongly that the use of technology such as electronic fetal monitoring and medications such as oxytocin are being used more frequently to accelerate the labour and delivery process. Although there are some benefits to using electronic fetal monitoring, it does little to enrich the experience of labouring women (Romano & Lothian, 2008). Participants acknowledged that providing labour support was greatly affected when using electronic fetal monitoring. Straps holding the monitors in place were identified as being a nuisance and restrictive to promoting ambulation. Participants described frequently going into a labouring woman's room to perform 'checks' on the paper tracing to document fetal heart rate and contraction patterns. Similarly, participants described the challenge with accurately and reliably monitoring women who have an increased body mass index and those who wish ambulate. Accordingly, participants disclose much to their dismay, and contradictory to the recommendations of research, nurses often end up requesting that women remain in bed or upright in a chair in order to accurately detect the fetal heart rate and contraction pattern (Kardong-Edgren, 2001; Romano & Lothian, 2008; Carlton et al., 2009). Curiously there was no mention by participants about the use of telemetry, wireless monitors to enable labouring women to ambulate while on continuous electronic fetal monitoring. Participants did not discuss directly the fetal health surveillance guidelines.

Some participants brought forward the challenge of a medical timetable of fitting the plan for childbirth as delineated by the obstetrician. As a result, the medical paradigm is then commenced by the obstetrician to expedite the birthing process using oxytocin and consequently electronic fetal monitoring. Participants indicate the overall effect of these interventions then requires continuous electronic fetal monitoring and thus, requiring ongoing managing of the machines. Participants explain this form of providing care, as mechanical care. They detail mechanical care as being in the patient's room frequently, however state it is not to provide labour support, but to perform 15 minute checks that include maternal and fetal assessments. Participants were clear in expressing the many challenges that they face with electronic fetal monitoring and that their preference would be to provide labour support to a woman who is not hooked up to a monitor and thus would enable ambulation and frequent change of positions. Participants portrayed entering the room and not looking at the patient but directly looking at the monitor and tracing. Participants describe having to remind themselves that there is a patient attached to the monitors.

Using electronic fetal monitoring has made the contributions of nurses somewhat obscure (Hoerst & Fairman, 2000; Barret & Stark, 2010). Intrapartum nurses are most often the primary health care professionals responsible for fetal heart monitoring (AWHONN, 2015). Electronic fetal monitoring has become recognized for monitoring maternal and fetal assessments even though it is often the nurse who notices any abnormalities and initiates resuscitative measures (Hoerst & Fairman, 2000; AWHONN, 2015). Moreover, utilization of medical interventions including electronic fetal monitoring has made the nurse not available to the patient and the patient invisible to the nurse (Hodnett et al., 2012). A participant described her experience as having to manage many tasks at once and suggesting that her presence in the room is really an

illusion of her providing labour support. She related her time spent in and out of the room as seeking another nurse to co-sign changes in the epidural and oxytocin, while managing equipment and cords. She imparted her desire to provide good labour support by coaching and instructing the patient throughout her contractions. Hoerst and Fairman (2000) describe the use of technology as having converted nursing assessments at the bedside through patient observation to one of continual surveillance. This has led nurses to rely more profoundly on machine-generated data than use of their own critical thinking. As a result, the use of managing equipment has distanced the intrapartum nurse from the labouring woman. Humanistic skills such as therapeutic touch and nursing presence that accompany the hands-on approach for maternal and fetal assessments during labour become negated when interconnected with technology (Hoerst & Fairman, 2000).

A shared belief among some participants was their approach to labour support when a woman has an epidural. Some participants made mention that they felt that their labour support was not required when an epidural was in place. Payant et al., (2008) in a study found similar findings that nurses may not associate women who have epidurals as needing "labour support" as labour support is often associated with only being provided when the patient is in pain. Participants professed that augmentation of labour with oxytocin most times is necessary after the epidural is administered. They further acknowledged there are many interventions that typically follow the administration of an epidural, most of them resulting in the limited ability for maternal movement and being confined to bed. Consequently, participants felt that their role entailed managing the epidural as task-oriented functions such as frequent charting of maternal and fetal assessments, and maintenance of equipment as opposed to providing labour support. Evidence supports that for first time mothers who receive an epidural, there is an increased risk

of longer labours, cesarean delivery, and other types of instrumental deliveries (Anim-Somuah, Smyth, Jones, 2011).

Contrary to most participants, a few participants discussed age and experience as individual factors related to the provision of labour support. Older and more experienced nurses reported providing more labour support while being able to balance managing the medical and technical interventions. They suggest the ability to be able to multitask was having learned how to provide labour support during a time when epidurals were not utilized regularly and as a result nurses would provide labour support during their entire12-hour shift. One participant explained it wasn't uncommon to go home after working your 12-hour day shift and return the next day and be assigned the same labouring patient. However, this is not the case now, as all participants currently reported a high epidural rate. Crozier, Sinclair, Kernohan, & Porter (2006) suggest that with the appropriate use of technology, it can be utilized to improve care, if the care is patient focused and not machine focused. Another participant attributes her ability to be able to multitask utilizing technology and providing labour support. Another participant pays tribute to her amount of experience and admits that she nurses with her ears a lot of the time. She explains she relies on her ears through experience and knowing when a woman is in transition by the sounds that she makes or needs to push or when a fetal heart rate is low.

Birthing Environment that Influences the Care that Intrapartum Nurses Provide

The current Society of Obstetricians and Gynecologists collaborative recommended guideline entitled *Joint Policy on Normal Childbirth* recommends continuous one-to-one labour support for labouring women (SOGC, 2008). A systematic review examining factors associated with women's satisfaction with the childbirth experience suggests that continuous labour support can make a significant contribution to a positive birthing experience (Hodnett et al., 2012).

Continuous labour support has been shown to improve birth outcomes, by decreasing cesarean sections rates, and the use of epidural analgesia, shortening labours, and decreasing the use of vacuum and forceps (Hodnett et al., 2012; AWHONN, 2018).

All participants acknowledged the guidelines and the significance of the research supporting continuous labour support. Participants further divulged that their usual practice is to attempt to provide continuous labour support, however, participants were expressive and articulate in outlining many challenges and barriers when endeavoring to provide this type of care. Participants described challenges of impeding this guideline such as staffing patterns, constraints of time, guidelines and policies that emphasize the use of technology, timelines of obstetricians and performing non-nursing duties.

The setting is a hospital where participants function in a nurse-managed unit in Northeastern, Ontario. The obstetrician is not consistently in-house and there are no other physicians on the floor available to consult with. At any given time, a patient may require emergency interventions necessitating the nurses to intervene until such time the obstetrician arrives at the hospital. Participants described practicing autonomously based on routine orders and medical directives. Participants discussed following pre-printed orders and using clinical decision-making. Examples provided were titration of oxytocin infusion based on progress of labour and maternal and fetal assessments in triage.

Participants practicing in a nurse-managed model describe the complex challenges inherent to the hospital, namely staffing, organizational influences, and medical and technical management of labour. Participants ardently expressed frustration at having to manage many tasks and patients at once as a result of the model of care. Participants identified the model of care as an LBRP (labour, birth, recovery, postpartum) model, where patients labour, birth,

recover and have their postpartum stay all in one room. Therefore, the census may range from antepartum, intrapartum, postpartum, postoperative and triage. Accordingly, participants shared that their patient assignment may range, however there is usually a nurse designated for triage, postpartum, and labour. Participants forcefully suggested that at any given time that was subject to change and all nurses were required to help out and support each other during busy times. This was described as being problematic for participants because they described many complex challenges of providing care to many patients and sometimes at once. They described the environment as being unpredictable and at times inefficient if there is a high census and especially if there is more than one labouring patient.

Staffing issues were a predominant concern among most participants. The findings from Sleutel et al.'s (2007) study are consistent indicating that intrapartum nurses reported inadequate staffing as factors preventing labour support. In order for intrapartum nurses to safely provide support for the labouring woman, adequate staffing is essential (AWHONN, 2018). The current recommendation for a labouring woman is a one-to-one nurse to patient ratio to endorse patient safety (AWHONN, 2018). The literature outlines many improved outcomes to labouring women when they receive continuous labour support. Edmonds, Hacker, Golen and Shah (2016) assert that nurses remain the main care provider for women in labour who give birth. Continuous labour support has been viewed as a form of pain relief, specifically, as an alternative to epidural analgesia (Hodnett et al., 2012). Despite the many benefits indicated, participants persistently describe the challenges they face upholding this recommendation. Nurses voiced great frustration with not enough staff to accommodate a busy unit and staffing complement. Participants described a significant feeling of being overwhelmed, guilty, torn and a sense of having to be in many places at the same time. In fact, some participants shared that when the

floor is very busy, they find that the labouring patients receive less support in order to attend to the other patients' needs on the floor. Conversely, some participants felt that the postpartum and newborn patients received less care in order to provide labour support.

Nurses are a self-regulating professional, and are responsible for acting professionally and being accountable for their own practice. The professional intrapartum nurse draws on a comprehensive knowledge base and clinical expertise to provide a standard care of practice (AWHONN, 2010; 2014). The actions of nurses have a significant impact on patient outcomes and patient satisfaction (Duffy & Hoskins, 2002; AWHONN, 2014). The attitude of nurses may sometimes be less influenced by years of experience than by prevalent intrapartum cultural attitudes toward labour support (Liva et al., 2012). Some participants expressed displeasure with some of their peers' professionalism and work ethic. Several participants made mention of nurses providing labour support from the nursing station and not being in the patient's room. Providing quality nursing care is a professional responsibility and an expectation by the patient (Duffy & Hoskins, 2002). The nursing station can provide a milieu for personal conversation unrelated to patient care (Adams, 2017). Furthermore, some participants felt as if their peers were judging them if they were spending too much time in the patient's room. Adams (2017) acknowledges that peer pressure within a birthing unit can be looked upon as herd mentality. Consequently this culture on the birthing unit makes it challenging for the nurse who wishes to oppose this behavior.

Interprofessional Collaborative Relationships

Nurses' relationships with interprofessional caregivers have become an important determinant in quality health care (Duffy & Hoskins, 2003). Participants defined their experience with the interprofessional team as positive but not without its challenges with maintaining a

balance in advocating for patient care and evidence based practice. Duffy and Hoskins (2003, p. 80) call nurses "the supportive glue that holds the health care team together for the benefit of the patient and family." Nurses spend a great deal of time initiating, fostering, and supporting caring relationships. It is the kindness of the nursing staff, the encouragement, warm smile and touch that women and their families recall (Simkin, 2002). The time spent establishing these relationships is often undervalued and disregarded part of professional nursing that is not considered by the medical model of health care (Duffy & Hoskins, 2003). Although participants frequently discussed many factors that hindered intrapartum care, nurses repeatedly indicated how much they valued working as a collaborative team. Participants for the most part, described feeling supported by nursing peers and obstetricians and glowingly take pride in an environment wherein they provide passionate care to all of the patients.

Nurses work independently and collaboratively to enhance the labour experience and improve birth outcomes (AWHONN, 2014). Nurses play an important role as part of the interprofessional team in intrapartum nursing. Medves and Davies (2005) suggest intrapartum nurses practicing in rural areas are usually considered to be multi-specialists and should have access to continuing education, interprofessional support and support from administrators Medves & Davies, 2005). Medves and Davies (2005, p. 34) outlined three factors for success and sustainability of a rural maternity unit, "mutual respect for each other's experience and caring, the understanding of the importance of continuing education to maintain and enhance skills, and the collaborative practice among members of the health care team." All participants echoed a feeling of needing to be supported. The need to feel supported by nurse peers and obstetricians were key to participants when talking about interprofessional collaboration. Participants were grateful for a nurse manager who advocates for staffing when necessary and

listen to their concerns. Practicing in a nurse-managed unit, participants believed they are knowledgeable in intrapartum care and that their contribution is important and essential to the quality of patient care. Some participants felt their contribution was valued in assessments, decision-making, communication, and others felt that communication at times could be tentative. Some participants discussed specific communication techniques and strategies when communicating with obstetricians. A participant described the need to feel comfortable and able to approach the obstetricians with any concerns or questions. Another participant describes using communication to advocate on behalf of the patient any wishes or concerns that they may not feel comfortable addressing.

Intrapartum Specialists

Adams (2017) infers many challenges in the workplace that may affect the care provided by an intrapartum nurse. These challenges could be external and not within control of the nurse, or internal potentially within the nurse's control (Adams, 2017). An external challenge includes features of the physical layout of the birthing unit such as the model of care, policies and guidelines, staffing, and intraprofessional communication and relationships. An internal challenge would include personal assumptions, values and beliefs related to birthing practices and knowledge related to evidence based practice (Adams, 2017). All participants when describing their experience of providing labour support identified examples of external and internal challenges. Some participants apprehensively implied a negative unit culture towards the provision of continuous labour support as a proposed challenge. Several participants made reference to the nursing desk as a place of social gathering. Participants alluded that the norm among nurses is to perform their frequent but brief "checks" on labouring patients and then return to the nursing desk. Some participants portrayed a feeling of being judged while spending

time in the patient's room. They explained that although they were in a patient's room providing labour support, they were regarded as not contributing to other nursing and non-nursing tasks. Hodnett (1997) suggests, "nurses who deviate from this norm risk being shunned, set apart, and even ridiculed by their peers" (p.79). Once a patient is discharged from the hospital, the nurse is no longer involved in their care, however, the nurse will work with their peers for many years. Adams (2017) implies the culture, norms and structure within an organization can influence birth practices and suggests that "the birth environment is not solely the physical space in which a family gives birth but also includes the type of birth practices occurring within and the positive and negative relationships of all who interact within the environment" (p.21). Peer pressure within nursing staff can be described as "herd mentality." If the majority of nurses exemplify certain behaviors, then the rest will typically follow. With increasing use of medical interventions, intrapartum nurses should be acquainted with current evidence-based practices to challenge the existing culture.

Knowing in nursing has been defined as integration of knowledge, experience, and intuition (Benner, Tanner, & Chesla, 2009). Knowledge allows intrapartum nurses to feel confident in their assessments, interventions and problem solving and decision-making. Nursing in obstetrics is a specialty and it takes time for intrapartum nurses to develop the knowledge and skills to become an expert nurse (Adams & Bianchi, 2008). Benner (2001) predicts it can take more than five years for nurses to develop expertise as an intrapartum nurse in labour support. A self-declared older and experienced participant expressed concern over the younger generation of nurses not having the knowledge and skills to provide hands-on labour support. She implies that the level of experience and comfort with providing emotional support and physical support is lessened with the new generation of nurses. She partially attributes this to the first time she's

ever worked with nurses who do not have children of their own. She suggests from her own experience that having children changes your perspective on how to provide labour support. She further acknowledged that having been a junior staff for many years, she received years of mentoring from nurses who were senior to her on how to provide labour support and recognizes how that positively impacted her care. In study by Payant et al., (2008) she echoes the sentiments of the participant and implies the new generation of nurses may not know how or what to do to provide continuous labour support as these nurses have been trained in an era of utilizing technology, electronic fetal monitoring and central fetal monitoring. Liva et al., (2012) suggest nurses with less experience may recommend epidurals to labouring patients more frequently or use electronic fetal monitoring as a result of their comfort level and lack of exposure to low-intervention birth practices. Providing care as an experienced intrapartum nurse requires the knowledge and skills to care for a low-risk patient but also quick critical thinking in response to unexpected emergencies. Barrett and Stark (2010) suggest a positive correlation between experience and increased amount of time providing labour support. While it is challenging to measure level of confidence, nurses with increased experience of providing labour support have an opportunity to become more comfortable and confident than less experienced nurses.

Nurses can enhance the birthing experience for women through a better understanding of their role within the intrapartum phase. To accomplish this, nurses need to be knowledgeable about what labour support is and how to provide it. Ryan, Goldberg & Evans (2010) describe relational learning as a way of understanding how nurses become knowledgeable and experienced through learning that occurs between nurses and between nurses and labouring women. The authors suggest that relational learning is central to mentoring to enhance the

evolution of intrapartum nursing expertise (Ryan et al., 2010). Mentoring is a method that includes preceptoring, role modeling, guidance and encouragement to pass on the knowledge and skill of labour support (Adams & Bianchi, 2008; Ryan et al., 2010). Sleutel (2002) notes that nurses who are knowledgeable and experienced can not only strengthen the coping abilities of labouring women by being assertive, supportive and responsive to the labouring woman by also their peers.

Experiential learning is another form of learning utilized in mentoring new nurses on how to provide labour support (Ryan et al., 2010). As mentioned earlier, an older and more experienced participant described how she was mentored as a junior staff member to provide labour support from senior nurses at a time when epidurals were not available. She reflected on her learning over time and how she was able to integrate the emotional support and physical support to provide the labour support she prides herself on giving. Sleutel (2002) reinforces that nurses who are knowledgeable and experienced can demonstrate role-modeling for their peers together with empower labouring women by enhancing their coping skills by being supportive and responsive to their needs. However, there is some concern identified

Application of Theoretical Framework

Symbolic interactionism provides a theoretical perspective on how individuals act towards and interpret objects based on the meanings that these objects have for them. Blumer (1969) advises the nature of the symbolic framework is derived from three premises:

> Human beings act towards things on the basis of the meanings that the things have for them. The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. Meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (p. 2)

Symbolic interactionism interprets meaning as a result of the process of interaction amongst people. The value of the meaning of a thing for a human develops through the ways in which interactions occur and how the interactions define the thing (Blumer, 1969). Meanings can be looked upon as social products, as creations that are shaped by and with activities as people work together. Two steps are involved in defining and creating a human's definition of meaning. In the first step, the human specifies things they are acting towards and then through interpretation applies their own meaning. Through this step, the human captures either through awareness or being unaware what signifies meaning within the situation (Blumer, 1969). The process is intrinsically social wherein the person although independent still may become dependent. In the second step the human defines and clarifies the meaning and the importance of controlling it. This process allows for a greater significance of the defined meaning Handberg, Thorne, Midtgaard, Nielsen & Lomborg, 2015).

The view of human action also applies to joint or collective action in which many individuals may be associated with as an outcome of interpretive interaction. Interlinkages of human action are the building blocks of human social interactions. The joint actions consist of a societal organization of conduct or various acts of diverse participants. Joint actions vary from a relationship of two individuals to a group. Joint actions may be deliberately entered into and then may be transferred without the necessity of separating the various individual actions that make them up or identifying the individuals who perform them (Blumer, 1969).

Intrapartum nurses providing labour support to women can be looked upon as a shared activity or creating joint action (Blumer 1969). Throughout the intrapartum experience, the nurse will influence, create, and shape the meaning and understanding of the labour experience. The joint action creates the therapeutic relationship with the labouring woman and her family

and the intrapartum nurse. To understand the meaning of the social interaction and experience, communication in the form of language, gestures, and symbolic objects are part of the formative process. The objects may be anything that can be referred to or designated (Blumer, 1969). The objects may be physical such as the labour and delivery room, electronic fetal monitor, or intravenous and social objects such as the intrapartum nurse and the woman and abstract objects such as policies of the institution, medical and nursing guidelines or humanistic labour support. The intrapartum nurse through an ongoing process of defining and interpreting their experience of labour support places meaning of their actions through a non-symbolic interaction or symbolic interaction.

As technology reigns supreme in intrapartum practice, nurses are challenged with how not to reduce the labouring woman as an object. Sadly, technology has further reduced women to the status of objects by enforcing a labour that is continually monitored by machines. Within such an environment the mandate of nursing is negated which attempts to view the woman more than an object. The medical paradigm exists that when a woman's labour doesn't follow the medical timeline, then augmentation is initiated with an intravenous, oxytocin and electronic fetal monitoring to expedite the birthing process. The overall effect of these interventions may cause intense contractions and anxiousness in the labouring woman, thus choosing to receive epidural analgesia. Furthermore, the interventions may place the patient at risk of requiring medical intervention such as an instrumental delivery or caesarean section. The accumulative effect of the increasing interventionist model results in a labour that requires the woman to be placed in a bed with wires and IV tubing and a nurse performing checks while viewing a machine. This is in opposition to the use of telemetry fetal monitoring if required, to receive continuous fetal surveillance that will permit women to remain upright and mobile.

Practice Implications

An optimal woman-centered model of practice links childbearing to the woman's health throughout the life span rather than isolating it as a separate event. Ideally, the woman is an active participant in making informed choices. The dominant culture in childbirth is the medical model that does not embrace woman-centered care. Rothman (1996) denotes many ways in which North America manages childbirth and has denied women power and control. She declares that birth in North America is not designed to support mothering, education or empowering women's strengths. Rothman (1996) implies childbirth within North America is: "Birth is about the efficient removal of a fetus; it is about getting a rather unwieldy object through a small space" (p.254). She suggests when a woman first identifies that she may be pregnant, a medical diagnosis is required to confirm the pregnancy. When she goes into labour and present to the hospital, she becomes the patient. The disrobing of the patient upon entering the birthing unit and being placed in a hospital gown and baring of intimate body parts begins the experience of invading personal space and converting women into units of management (Rothman, 1996). The onset of labour also requires a medical diagnosis to determine what stage of labour she falls under. There are specified criteria that define when a woman's body is in true labour versus false labour regardless of the contractions she is feeling. Once she is deemed to be in true labour according to a medical confirmation, her body and more precisely the uterus and cervix are required to meet timely progression throughout labour. Failure to do so may necessitate further medical and technological intervention and possibly even a surgical intervention.

Throughout the twentieth century, the birthing experience has evolved from an event that occurred at home attended by midwives, family or friends to a short, inpatient stay at the

hospital, that is medically managed in a technological environment (Sherrod, 2017). Within this time rapid changes have taken place affecting the role of the nurse. The medical model approach has changed from a normal physiological birth to one that has become focused on risk and technological interventions (Sherrod, 2017). Today's birthing process involves interventions that require the use of medications and technology and as a result has rendered the nurse's role to being procedure-intensive (Barrett & Stark, 2010; Sherrod, 2017). The demands placed upon the intrapartum nurse may supersede the emotional and physical comfort measures provided for labouring women. Sandelowski (2000) claimed, "the link between nursing and technology became more problematic and perplexing…Indeed, it became more difficult to disentangle nursing and technology, as nursing was depicted both as a technology itself and as an antidote to technology" (p. 2). Sherrod (2017) suggests the labouring woman's "…expectations and emotional needs are secondary, and the birth experience is overly standardized, task oriented, needlessly aggressive, and physician and hospital controlled" (p. 628).

Edmonds, O'Hara, Clarke & Shah (2016) in a retrospective study looked at intrapartum nurses' ability to influence a cesarean birth in a nurse-managed labour model. The researchers examined the variation in the cesarean birth rates of women being cared for by intrapartum nurses. The findings from the study suggested that the nurse assigned to a woman may influence the likelihood of cesarean birth. They postulate some of the reasons as differences between individual nurses such as education level, intrapartum skills and experience, and beliefs about practice. Edmonds et al. (2016) advise in order to demonstrate quality improvement; elimination of avoidable practice variation can lead to improved intrapartum outcomes and a better use of resources. Clark, Belfort, Hankins, Meyers & Houser (2007) suggest an example of practice variation is the interpretation of electronic fetal monitoring. They propose that there is

subjectivity in interpretation of data, which may often influence the clinical decision making of nurses. Furthermore, evident in this study was that nurses continue to struggle to balance the needs of the labouring woman in the face of many barriers that impede the ability to provide one-to-one labour support (Edmonds et al., 2016). The organizational environment must be favorable and supportive for the provision of labour support. Effective interprofessional team practices need to be considered when developing practical interventions that will increase the nurse's amount of time spent with the labouring woman (Edmonds et al., 2016).

Intrapartum nurses are in a unique position to sustain the care practices that support a normal physiological birth. Nurses describe health care systems that for the most part were not designed for women centered childbirth. The heart of nursing is providing individualized care, promoting comfort, and addressing emotional needs within a holistic health model (Payant et al., 2008). Labour support within a technological environment and medical paradigm has demonstrated drastic changes within intrapartum nursing care (Barret & Stark, 2010; Fleming, Smart & Eide, 2011). With the concurrent use of technology such as electronic fetal monitoring, intravenous infusions, different forms of analgesia and high-risk medications, for nurses providing evidence-based nursing care that promotes, protects, and supports normal birth has become a challenge (Zwelling, 2010). Nursing care must expose and minimize barriers to woman-centered care that are embedded in the health care system. Routine protocols and orders for labour admission should be reevaluated for the requirement of unnecessary interventions for all women.

There is substantial evidence that supports the many benefits of labour support provided by intrapartum nurses. Intrapartum nurses need to be supported to promote and sustain care practices that embrace woman-centered care. Labour support should be regarded, as an

intervention that supports education and competence validation is required. An additional recommendation would be a certification that provides the theoretical basis on the advantages to both the woman and her fetus on labour support. However, education alone detailing the benefits of labour support is not sufficient enough. The certification would include a practical and component including simulation on how to appropriately apply the techniques of comfort measures together with guidance and suggestions on providing emotional support. Woman-centered pedagogy and philosophy would be embedded throughout. Adams and Bianchi (2008) recommend intrapartum nurses be required to complete certifications in labour support as they do for electronic fetal monitoring and other additional certifications outside the scope of the RN. Continuing education is important to implement evidence-based practice (Davies & Hodnett, 2002; Miltner, 2000; Payant et al., 2008). Kardong-Edgren (2001, p. 372) supports regular learning opportunities for labour support skills. She notes, "this is a generation of nurses who have practiced only in an era of fetal monitors and may not know how to provide one-to-one labour support to a labouring woman." Simkin (2002) authors a guide for nurses on supportive care with strategies designed for each phase of labour. The guide also offers phrases and questions to assist the nurse on what to say to the labouring woman at each phase of labour.

Patient safety is a mandatory element of intrapartum care and a fundamental measure of quality care within a hospital (Adams, 2017). Normal physiological birth is associated with positive maternal, fetal and newborn outcomes and safety can be further enhanced with embedding evidence-based practice into the implementation of intrapartum care (Adams, 2017). When an organization including its stakeholders and administrators support continuing education, opportunities to promote labour support foster a positive and safe environment amongst patients, families, nurses and obstetricians (Adams, 2017). Without this support, a

medicalized approach prevails which involves higher rates of interventions during labour and birth.

Limitations

There were some limitations to this research study. The first limitation was homogeneity of the participants. All participants were women and registered nurses who provide intrapartum labour support in one setting. Accordingly, the sample may not be representative of other intrapartum nurses in different childbirth settings. The setting featured one model of care, the LBRP setting. There may have been different experiences from intrapartum nurses who work on a labour and delivery unit with a separate postpartum floor.

The sample size was eight participants and is considered small, however in qualitative research, the sample size is less significant than reaching data saturation. Data saturation occurs when saturation of the research is reached data collection and categories and themes start to reoccur and no new information is gathered from the research (Rubin & Rubin, 2012). When data saturation occurs, it is time to stop research. Morse (2000) claims that with a broad research question, it will take longer to reach data saturation. Data saturation in this study was reached after eight interviews. Lastly, although the researcher used thick description by using direct quotations from participants, transferability may be limited to other maternity care settings.

Future Research

This interpretive descriptive qualitative research study has provided important insight into the experience of intrapartum nurses. This study discussed the meaning of, and experience of the nurses with implementing labour support together with the barriers and challenges on providing labour support. Almost all participant discussions focused on the utilization of technology and medicalization of care during labour. There is a need for further research

investigating the definition of labour support together with how the nurse's presence in the room is supportive and how nurses determine who needs labour support. Almost all nurses identified the challenge of the current model of care, the LBRP room, wherein patients' labour, birth, recover and have their postpartum stay in the same room. Further research is needed to examine how the structure of labour and delivery units influences the provision of intrapartum nursing care. Further research may also include an investigation into how prenatal education such as birthing preparatory classes are being offered with the shift from a natural birth movement to intervention-intensive labour including pain management.

Conclusion

The findings of this study describe the experiences of intrapartum nurses and the meaning they place on providing labour support. Eight participants were recruited using a purposive sampling technique for the study. All of the participants practiced at the same hospital. The study was designed to investigate the research question: What are the experiences of intrapartum nurses in Northeastern Ontario setting in providing labour support? Through semi-structured interviews and conversation, the researcher was able to develop a richer understanding of the experiences and meaning placed on providing intrapartum labour support. There were five themes that emerged from the data: Enhancing the birthing experience of women through labour support, birthing technology and medical paradigm, birthing environment that influences the care that intrapartum nurses provide, interprofessional collaborative relationships, and intrapartum specialists.

Multiple definitions of labour support exist within the literature. Almost all definitions agree on the components that comprise labour support such as emotional support, information about labour progress and advice regarding coping techniques, comfort measures and advocacy

(Simkin, 2002; Hodnett et al., 2003; Sauls, 2006; Liston, et al., 2007; AWHONN, 2018). Participants in this study described a similar definition when providing labour support, but have expanded their definition to include managing the technological aspects of labour. The findings of the study accentuate the technological and medicalization of labour support.

The contrast between a woman-centered birth and a technological and medical centered birth was evident from the nurses' experiences and their meaning of providing labour support. Feminist theory was used as a perspective to view feelings and thoughts of oppression that have been traditionally revealed in nurses' experiences as caregivers of women in a patriarchal environment. Because nurses often provide care to women at critical developmental points, it is important that the practice of nursing reflect the principles of feminism (Sampselle, 1990). By challenging traditional attitudes and values, nurses can have a beneficial effect on women's self-concept (Sampselle, 1990). Incorporating feminist philosophy into practice can make it more likely for women to become equal partners in their birthing experience.

As labouring women are more and more constrained by the standards that embody today's modern obstetrics, critical theorists suggest that women giving birth have been fundamentally reduced to an object, which is synonymous with physical machines (Goldberg, 2001). Drastic changes in obstetrics within North America have lead to increased use of birthing technology and a medical paradigm. Goldberg (2002, p. 446) believes that the medicalization of birth has led to a "dehumanization of the birthing experience", profoundly influenced by the Cartesian duality of scientific thought, the separation of mind and body. The researcher believes this view has saturated intrapartum nursing practice and reduced labour support to predominantly technology driven tasks, caring for women as if they are physical objects or machines. Other important factors have contributed to the impact of decreased labour support such as a constantly

changing census of patients affecting safe staffing levels, changing demographics of the childbearing women, the labour, birth, recovery, postpartum model, an obstetrician's medical timeline and an awareness of a medical litigious environment.

Intrapartum nurses have been drawn away from providing labour support and have become preoccupied with managing technology and other non-patient care activities. This research supports nurses in wanting a paradigm shift from the prevailing medical model to a normal physiological birth model that includes evidence-based practice. Unnecessary use of technology and routine interventions that currently dominate the current intrapartum model, predispose women to higher rates of medical interventions and cesarean births. Providing labour support from a normal physiological birth model was embedded as a vision. Brubaker and Dillaway (2009) infer that technology usurps the labour experience once a patient is admitted to the hospital. This is accomplished through trusting and relying on technology as opposed to women-centered care. Brubaker and Dillaway (2009) suggest that women follow a medical model of care because they do not question the technological or medical interventions or are convinced that it is the best method for them.

The findings demonstrated intrapartum nurses valued and placed meaning on providing labour support inclusive of emotional support, physical comfort measures, informing and advocating. However, nurses often struggled with the challenge of finding a balance between the provisions of labour support and managing the barriers and obstacles that hindered their ability to provide optimal intrapartum care. The findings pointed to nurses experiencing considerable dissatisfaction, distress and being disheartened when barriers constrained them from rendering quality intrapartum care. In contrast, they felt a great deal of pride, pleasure and gratification when they could offer the labour support they envisioned providing.

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Appendix A

Research Study Information Letter

LaurentianUniversity
UniversitéLaurentienne

Participant Information Letter

You are being invited to participate in a research study entitled: ***The experiences of Northeastern Ontario intrapartum nurses' providing labour support.*** You are being asked to take part in this study because you are a registered nurse practicing perinatal nursing. This study has been reviewed for ethical compliance by the Research and Ethics Board at Laurentian University and (NBRHC) or (Health Sciences North). The Research Ethics Board is responsible for safety, rights and well being of all human subjects participating in research.

Before you make a decision, it is important that you are aware of what the research in this study involves. The purpose of this letter is to inform you about the nature of the study, including the procedures involved, and the possible benefits/risks involved in taking part of the study.

Researcher: My name is Ylise Dobson. I am a graduate student attending Laurentian University in the Masters of Science in Nursing Program. As partial fulfillment of the degree, I am conducting a research study under the supervision of my thesis adviser, Roberta Heale. I am employed at NBRHC as a staff nurse working in the birthing unit. Therefore, while conducting this study, I hold a dual role as staff nurse and student researcher at NBRHC. If you would like to participate in the study and are uncomfortable with the dual role that I hold, I will arrange for you to speak with Roberta Heale, my thesis advisor or you may contact Roberta directly who will arrange for a third party to interview you.

Purpose of study: To explore the experiences of Northeastern Ontario intrapartum nurses while providing labour support.

Procedure of study: If you consent to participate in the study, your involvement will be approximately 30 minutes in one face-to-face interview or telephone interview that will be scheduled at your convenience. You will be asked to share your experiences of providing intrapartum support on providing labour support. The interviews will take place in a quiet, private and confidential safe space to be designated by the participant (ie. meeting room at the hospital, library located at university or hospital, cafeteria at hospital, designated quiet areas of hospital, available office at hospital). The interview will take place during your non-working hours. The interview will be recorded using a digitally audio-recorded.

Participation in this study is voluntary: Participation is this research study is completely voluntary. You have the right to withdraw at any time or refuse to answer any of the questions during the interview without penalty or consequence. You may request that the researcher cease

asking questions at any given time. Please be aware that participating or not participating in the study will not in any way affect you.

Confidentiality and storage of data: Your participation in the study is confidential. A pseudonym will be assigned for you as a study participant throughout this research to protect the confidentiality of the data that you share. All data will be analyzed at a group level in order to de-identify individuals in the research findings. All data will be kept in a locked filing cabinet and encrypted password protected USB at Ylise Dobson's residence. The data will be saved for one year after completion of the study and at that time will be shredded and disposed of by Ylise Dobson.

Potential risks, harms or discomforts: Participation in this study is voluntary and there are no consequences to choosing not to participate in the study. You have the right to withdraw at any time without penalty or consequence. There are no known foreseeable risks, harms or discomforts with you sharing your experience of providing labour support. If you feel uncomfortable, or distressed, the interview will be stopped. At that time, you will be provided with the hospital Employee Assistance Program (EAP) resources and community counseling services contact information if needed. Ylise Dobson may be obligated to report any knowledge of unsafe, unprofessional or unethical practice that could result in the harm of others that is disclosed during the interview. If there are any such disclosures, Ylise Dobson will discuss any intent to report with the study participant after the interview.

Potential benefits to study participants: Study participants may find being asked about their experiences and or reflecting on their experiences beneficial and this would be subjective to each participant. The information you provide may contribute to nursing's body of knowledge and improve the quality of nursing and patient care.

Compensation: There are no financial incentives to participate in this study

Dissemination of study results: A copy of the completed research study will be given to the clinical nurse educator at NBRHC and HSN to be placed in the staff lounge for you to read. All references to individual participants will be removed when reports, presentations, and discussions are prepared, thereby protecting your confidentiality.

Contacts: If you have any questions about this study please contact the researcher Ylise Dobson at: ydobson@laurentian.ca or faculty thesis supervisor Roberta Heale at: rheale@laurentian.ca or 705-675-1151 or 1-800-461-4030 ext. 3971.

Study participants may contact an official not attached to the research team regarding possible ethical issues or complaints about the research itself: Research Ethics Officer, Office of Research Services at: ethics@laurentian.ca or telephone: 1-800-461-4030 or 705-675-1151 ext 3681 or 2436.

Appendix B

Consent Form

Title of study: The experiences of intrapartum nurses in Northeastern Ontario, Canada settings in providing labour support.

Researchers: Ylise Dobson (student researcher), Roberta Heale (thesis advisor)

- I have read the information about the study being conducted by Ylise Dobson, graduate nursing student at Laurentian University, as part of her graduate thesis.
- I am aware of the potential conflict of interest of Ylise Dobson in a dual role as student researcher and colleague at NBRHC (if applicable). I have been presented with the option of having a third party researcher arranged through Roberta Heale, thesis advisor.
- I have been provided the attached Letter of Information. Ylise Dobson has discussed this study with me and I have been given the opportunity to inquire about details of the research study to decide whether or not to participate in it.
- The possible benefits and risks that could arise as a result of the study have been explained to me.
- I understand that Ylise Dobson has a duty to report any knowledge of unsafe, unprofessional or unethical practice that could result in the harm of others that is disclosed during the interview. If there are any such disclosures, Ylise Dobson will discuss any intent to report with the study participant after the interview.
- I have been assured that the data that I share will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission.
- I understand that my participation in this study is voluntary and that I can withdraw at anytime without any kind of consequence.
- All of my questions have been answered to my satisfaction.
- My signature below indicates that I voluntarily consent to participate in this study and allow the student researcher to digitally audio-record my interview.
- I have received a signed copy of this consent for my records.

I hereby give my informed consent to participate.

_____ _____

Signature of the study participant Date

Signature of the student researcher	Date

Appendix C

Recruitment Poster

LaurentianUniversity
UniversitéLaurentienne

Perinatal Registered Nurses

Who provide intrapartum labour support

Invitation to participate in research study exploring the experiences of intrapartum nurses in Northeastern Ontario settings who provide labour support.

Ylise Dobson RN, BScN, PNC(c), MScN(c)

Laurentian University School of Nursing Email: ydobson@laurentian.ca

Please contact for more information about this study

If you would like to participate in the study and are uncomfortable with the dual role that I hold as staff nurse and researcher, I will arrange for you to speak with Roberta Heale, my thesis advisor, or you may contact Roberta directly, who will arrange for a third party to interview

you. rheale@laurentian.ca or 705-675-1151

or 1-800-461-4030 ext. 3971

Appendix D

Interview Guide

LaurentianUniversity
UniversitéLaurentienne

Interview Guide

The purpose of this study is to explore ***the experiences of Northeastern Ontario intrapartum nurses' providing labour support.*** I will have some specific questions to discuss with you, however I would like the discussion to be informal so that you can respond to any of the ideas or questions that arise. If you don't understand a question or require clarification, please don't hesitate to ask. Please feel free to speak openly and honestly, as there are no right or wrong answers. You may stop the interview at any time if you are uncomfortable with any of the questions.

You have already been provided the study information letter and have signed the informed consent, which describes the study in detail. As a reminder, I will be recording this interview. Do you have any other questions before we begin?

[Turn on audio recorder]

This is Ylise Dobson conducting *[interview with pseudonym name]* on *[date and starting time]*

1. **What is your definition of labour support?**

2. **What is your experience with providing labour support? What do you do to provide support and care?**

3. **The current SOGC collaborative recommended guideline entitled *Joint Policy on Normal Childbirth* recommends continuous one-to-one labour support for labouring women. When providing labour support, what, if any challenges and/or barriers do you encounter upholding this recommendation?**

4. **What is your experience with providing intrapartum labour support using medical/technical interventions? (Intravenous, use of high risk medications, eg. oxytocin, MgSO4, induction of labour, augmentation of labour, operative deliveries, eg. vacuum, forceps, epidural anesthesia/analgesia, ceasarean birth, electronic fetal monitoring, central fetal monitoring, if applicable)**

5. **What barriers/facilitators have you experienced with providing intrapartum labour support? In your experience, what helps you to provide good support and what makes it difficult to provide support?**